APPENDICES

APPENDIX A: Washington Law and Rule

RCW 48.43.045 Health plan requirements -- Annual reports -- Exemptions.

Every health plan delivered, issued for delivery, or renewed by a health carrier on and after January 1, 1996, shall:
(1) Permit every category of health care provider to provide health services or care for conditions included in the basic health plan services to the extent that:
(a) The provision of such health services or care is within the health care providers' permitted scope of practice; and
(b) The providers agree to abide by standards related to:
(i) Provision, utilization review, and cost containment of health services;
(ii) Management and administrative procedures; and
(iii) Provision of cost-effective and clinically efficacious health services.
(2) Annually report the names and addresses of all officers, directors, or trustees of the health carrier during the preceding year, and the amount of wages, expense reimbursements, or other payments to such individuals. This requirement does not apply to a foreign or alien insurer regulated under chapter 48.20 or 48.21 RCW that files a supplemental compensation exhibit in its annual statement as required by law.

NEW SECTION

WAC 284-43-205 Every category of health care providers.

(1) To effectuate the requirement of RCW 48.43.045 that health plans provide coverage for treatments and services by every category of provider, health carriers shall not exclude any category of providers licensed by the state of Washington who provide health care services or care within the scope of their practice for conditions covered by basic health plan (BHP) services as defined by RCW 48.43.005(4). If the BHP covers the condition, the carrier may not exclude a category of provider who is licensed to provide services for that condition, and is acting within the scope of practice, unless such services would not meet the carrier's standards pursuant to RCW 48.43.045 (1)(b). For example, if the BHP provides coverage for outpatient treatment of lower back pain, any category of provider that provides cost-effective and clinically efficacious outpatient treatment for lower back pain within its scope practice and otherwise abides by standards pursuant to RCW 48.43.045 (1)(b) may not be excluded from the network.
(2) RCW 48.43.045 (1)(b) permits health carriers to require providers to abide by certain standards. These standards may not be used in a manner designed to exclude categories of providers unreasonably. For example, health carriers may not decide that a particular category of provider can never render any cost-effective or clinically efficacious services and thereby exclude that category of provider completely from health plans on that basis. However, health carriers may determine that particular services for particular conditions by particular categories of providers are not cost-effective or clinically efficacious, and may exclude such services from coverage or reimbursement under a health plan. Any such determinations must be supported by relevant information or evidence of the type usually considered and relied upon in making determinations of cost-effectiveness or clinical efficacy.
(3) Health plans are not prohibited by this section from placing reasonable limits on individual services rendered by specific categories of providers. However, health plans may not contain unreasonable limits, and may not include limits on the type of provider permitted to render the covered service unless such limits comply with RCW 48.43.045 (1)(b).
(4) This section does not prohibit health plans from using restricted networks. Health carriers offering plans with restricted networks may select the individual providers in any category of provider with whom they will contract or whom they will reimburse. A health carrier is not required by RCW 48.43.045 or this section to accede to a request by any individual provider for inclusion in any network for any health plan. Health plans that use "gatekeepers" for access to specialist providers may use them for access to specified categories of providers.
(5) Health carriers may not offer coverage for health services for certain categories of providers solely as a separately priced optional benefit.
(6) The insurance commissioner may grant reasonable temporary extensions of time for implementation of RCW 48.43.045 or this section, or any part thereof, for good cause shown.
(7) All health carriers and their plans, provider contracts, networks and operations shall conform to the provisions of this section WAC 284-43-205, by January 1, 2000.

APPENDIX B: Professions Regulated by the Department of Health

LICENSED PROFESSIONS

Profession	RCW	WAC	Disciplining Authority	# Currently Credentialed*	Fee charged for Credentialing	Fee charged for Renewal	Birthday Renewal Period
Acupuncture	18.06	246-802	Secretary of Health	509	$200	180 (Active) 110 (Inactive)	1 yr
Advanced RN Practitioner	18.79	246-840	Nursing Care Quality Assurance Commission	2,941	$65	50	2 yrs
Animal Technician	18.92	246-935	Veterinary Board of Governors	723	$80 (Nat'l Exam) 80 (St Exam) 60 (Init Regis)	51	1 yr
Chiropractor	18.25	246-808	Chiropractic Quality Assurance Commission	2,258	$300 (Exam) 200 (Orig license)	270	1 yr
Dentist	18.32	246-817	Dental Quality Assurance Commission	4,997	$325 (With exam) 700 (Without exam)	205	1 yr
Dental Hygienist	18.29	246-815	Secretary of Health	3,986	$100 300 (Credentialing Application)	60	1 yr
Denturist	18.30	246-812	Secretary of Health	91	$1,000 (Application) 1,500 (Exam)	2,750 2yr	2 yrs
Dispensing Optician	18.34	246-824 246-852	Secretary of Health	1,354	$200 (Exam)	100	1 yr
Hearing Instrument Fitter/Dispenser	18.35	246-828	Board of Hearing & Speech	310	$125 (Application) 100 (Exam) 100 (Initial license)	200	1 yr
Licensed Practical Nurse	18.79	246-840	Nursing Care Quality Assurance Commission	13,788	$65	50	1 yr
Massage	18.108	246-830	Secretary of Health	8,022	$150 (Nat'l Bd Exam) 55 (Initial license)	40	1 yr
Midwife	18.50	246-834	Secretary of Health	105	$375 (Exam) 375 (Initial application)	495	1 yr
Naturopath	18.36A	246-836	Secretary of Health	419	$50 (Application) 50 (Init License) 50 (St Exam)	450	1 yr
Nursing Home Administrator	18.52	246-843	Board of Examiners for Nursing Home Administrators	494	$325 (Application: Exam/Original license) 295 (Without exam)	295	1 yr
Occupational Therapist	18.59	246-847	Board of Occupational Therapy Practice	2,097	$90 (Application) 80 (Initial license)	125	2 yrs
Occupational Therapist Asst	18.59	246-847	Board of Occupational Therapy Practice	587	$90 (Application) 80 (Initial license)	95	2 yrs
Ocularist	18.55	246-849	Secretary of Health	5	$250	225	1 yr
Optometrist	18.53 18.54	246-851 246-852	Optometry Board	883	$250	125	1 yr

Profession	RCW	WAC	Disciplining Authority	# Currently Credentialed*	Fee charged for Credentialing	Fee charged for Renewal	Birthday Renewal Period
Orthotics/Prosthetics	18.200	246-850	Secretary of Health	89	$600	575	1 yr
Osteopathic Physician & Surgeon	18.57	246-853	Board of Osteopathic Medicine and Surgery	647	$500	375 (Active) 265 (Inactive)	1 yr
Osteopathic Physician Asst	18.57A	246-854	Board of Osteopathic Medicine and Surgery	48	$150 50 (Practice plan)	65	1 yr
Pharmacist	18.64	246-863...	Board of Pharmacy	6,259	(origin app) $120 (reciprocity) $300 (score trans) $240	125	**
Pharmacies & Other Pharmaceutical Firms	18.64 18.64A	246-869...	Board of Pharmacy	2,060	***$330	240	**
Physical Therapist	18.74	246-915	Board of Physical Therapy	3,652	$150	70	1 yr
Physician	18.71	246-919	Medical Quality Assurance Commission	18,015	$300 $25 (to impaired practitioner program)	225 $25 (to impaired practitioner program) 450 2yr	1 yr or 2 yr
Physician Asst	18.71A	246-918	Medical Quality Assurance Commission	1,295	$50 $25 (working on rules for adding $25 for impaired practitioners)	60 $25 (working on rules for adding $25 for impaired practitioners) 120 2yr	1 yr or 2 yr
Podiatrist	18.22	246-922	Podiatric Medical Board	251	$500 (Exam) 400 (Without exam)	650 (Active) 175 (Retired Active) 160 (Inactive)	1 yr
Psychologist	18.83	246-924	Examining Board of Pscyhology	1,517	$250 (Application) 80 (Admin written exam) 350 (Written exam) 250 (Oral exam)	275	1 yr
Registered Nurse	18.79	246-840	Nursing Care Quality Assurance Commission	59,750	$65	50	1 yr
Veterinarian	18.92	246-933	Veterinary Board of Governors	1,931 Active 784 (Inactive Reired)	$165 (Nat'l bd exam) 140 (Clinical competency test) 125 (State exam) 105 (Initial state license)	105 (active) 55 (retired active)	1 yr

CERTIFIED PROFESSIONS

Profession	RCW	WAC	Disciplining Authority	# Currently Credentialed*	Fee charged for Credentialing	Fee charged for Renewal	Birthday Renewal Period
Audiologist	18.35	246-828	Board of Hearing & Speech	254	$125 (Application) 100 (Initial cert)	200	1 yr
Dietitian	18.138	246-822	Secretary of Health	675	$100	45	1 yr
Health Care Asst	18.135	246-826	Secretary of Health	9,882	$35	83	2 yrs
Marriage & Family Therapist	18.19	246-810	Secretary of Health	811	$100 (Application) 125 (Initial certification) $50 (admin exam fee)	200	1yr
Mental Health Counselor	18.19	246-810	Secretary of Health	3,312	$75(Application) 60 (Initial certification)	29	1 yr
Nursing Asst	18.88A	246-841	Secretary of Health	27,847	$10 (Application)	20	1 yr
Nutritionist	18.138	246-822	Secretary of Health	45	$100	45	1 yr
Pharmacy Technician	18.64,18.64 A	246-901	Board of Pharmacy	4,755	$40 (Initial Cert)	35	1 yr
Radiologic Technician	18.84	246-926	Secretary of Health	3,168	$50 (Application 30 (Exam)	50	2 yrs
Respiratory Care Practitioner	18.89	246-928	Secretary of Health	2,051	$ 85 (Application) 110 (Exam)	50	2 yrs
Sex Offender Treatment Provider							1 yr
Fully Certified	18.155	246-930	Secretary of Health	91	$650 (Appl/Exam) 100 (Initial Certification) 300 (Appl/Exam)	800	
Affiliate Renewal				51	50 (Initial Certification)	300	1 yr
Social Worker	18.19	246-810	Secretary of Health	2,538	$50 (Application) 50 (Initial Certification)	42	1 yr
Speech Language Pathologist	18.35	246-828	Board of Hearing & Speech	623	$125 (Application 100 (Initial certification)	200	1 yr

REGISTERED PROFESSIONS

Profession	RCW	WAC	Disciplining Authority	# Currently Credentialed*	Fee charged for Credentialing	Fee charged for Renewal	Birthday Renewal Period
Adult Family Home Provider Resident Manager	18.48	246-328	Secretary of Health	2,987 456	$90	85	1 yr
Chiropractic X-Ray Technician	18.25	246-808	Chiropractic Quality Assurance Commission	210	$25 (Exam) 25 (Orig reg)	40	1 yr
Counselor	18.19	246-810	Secretary of Health	16,259	$40(Application)	37	1 yr
Hypnotherapist	18.19	246-810	Secretary of Health	302	$95 (Application)	130	1 yr
Nursing Asst	18.88A	246-841	Secretary of Health	16,291	$10 (Application	20	1 yr
Nursing Pool Operator	18.52C	246-845	Secretary of Health	100	$175	115	1 yr
Pharmacy Asst	18.64 18.64A	246-856...	Board of Pharmacy	#'s not available	1	No fee	**
Pharmacy Interns	18.64	246-858	Board of Pharmacy	659	$15	15	**
Vet Medication	18.92	246-937	Veterinary Board of Governors	220	$24	24	1 yr
X-Ray Technician	18.84	246-926	Secretary of Health	1,517	$35 (Application	35	2 yrs

APPENDIX C: Factual Chronology of Legal Events

Factual Chronology

Of Legal Events Related to RCW 48.43.045

April 1993	**The Washington State legislature adopted the "every category of provider" mandate as part of the 1993 Health Care Reform Act.**
April 1995	**The Washington State legislature adopted the every category of provider mandate in RCW 48.43.045. The statute was to be effective January 1, 1996.**
August 1995	**The Insurance Commissioner sent a letter dated August 18, 1995 to the CEO's of all disability insurers, HCSC's and HMO's requesting the submission by September 15, 1995, of a time line and work plan for achieving an adequate network of every category of provider.**
September 1995	**Carriers submitted plans as requested by the Insurance Commissioner.**
December 19, 1995	**The Insurance Commissioner issued Bulletin 95-9 setting forth the Commissioner's interpretation of RCW 48.43.045. None of the carriers' previously submitted plans would satisfy that interpretation.**
January 8, 1996	**Carriers filed a lawsuit in Thurston County Superior Court, sub nom *Blue Cross of Washington and Alaska v. Senn*, to have a court decide the correct interpretation of RCW 48.43.045.**
April 8, 1996	**Superior Court dismissed lawsuit due to carriers lack of exhaustion of their administrative remedies.**
May 21, 1996	**Carriers filed a Petition for a Declaratory Order to have the Insurance Commissioner decide the correct interpretation of RCW 48.43.045.**
August 21, 1996	**The Insurance Commissioner issues the Declaratory Order requested by the carriers.**
August 1996	**Carriers sue the Insurance Commissioner in Thurston County Superior Court, asking the court to reverse the Declaratory Order and stay all enforcement of it.**

September 1996	**Carriers sue the Insurance Commissioner in Federal (Employee Retirement Income Security Act) preempts state implementation of RCW 48.43.045 as to employer plans.**
September, 1996	**Superior Court orders enforcement of Declaratory Order stayed until the court can decide whether the Commissioner interpreted RCW 48.43.045 correctly.**
December 11, 1996	**Insurance Commissioner convenes carriers and provider groups for discussion regarding RCW 48.43.045.**
January 3, 1997	**Insurance Commissioner facilitates provider discussions regarding provisions of RCW 48.43.045.**
January 6, 1997	**Insurance Commissioner facilitates discussions between the carriers and providers regarding RCW 48.43.045. Providers present proposals for implementation.**
January 23, 1997	**Insurance Commissioner facilitates discussions between carriers and providers regarding RCW 48.43.045. Providers deliver further proposals for implementation.**
February 6, 1997	**Commissioner reviews measures presented by the carriers for implementation of RCW 48.43.045. Office of the Insurance Commissioner prepares plan matrix of currently covered benefits for alternative providers.**
April-May 1997	**Commissioner prepares for a facilitated meeting with providers and carriers to discuss clinical aspects of alternative therapies in health plans.**
May 2, 1997	**Federal District Court rules that ERISA preempts state implementation of RCW 48.43.045.**
May 9, 1997	**Insurance Commissioner files a motion in Federal District Court to clarify whether the court's May 2nd ruling applies to non-ERISA governed health plans.**
May 30, 1997	**Insurance Commissioner files an appeal with the 9th Circuit Court of Appeals of the May 2, 1997 ruling that preempts RCW 48.43.045 from ERISA plans.**

May 30, 1997	**Insurance Commissioner supports a facilitated meeting of health plan medical director's and representatives of alternative provider professions discussing clinical aspects of alternative therapies in health plans.**
July 23, 1997	**Federal district court denies the Commissioner's motion to clarify the ruling.**
July 30, 1997	**Insurance Commissioner refiles the appeal to the 9th Circuit Court of Appeals.**
September 29, 1997	**Washington state brief filed with the Ninth Circuit Court of Appeals. Amicus briefs filed in support of the position of the Office of the Insurance Commissioner by U.S. Department of Labor, National Association of Insurance Commissioners and provider groups.**
May 7, 1998	**Oral Argument in 9th Circuit Court of Appeals.**
June 18, 1998	**9th Circuit Court of Appeals reverses the lower court and directs summary judgement be entered in favor of the state.**
July 3, 1998	**Plaintiffs petition the 9th Circuit for a re-hearing on it's June 18, decision.**
August 24, 1998	**Ninth Circuit denies the plaintiff's petition for are-hearing, and rejects the plaintiff's state law arguments under 48.47.005-030, in addition to the ERISA claims rejected in it's June 18 decision.**
September 17, 1998	**Plaintiff's notify Thurston County Superior Court they will file a "petition for Writ of Certiorari with the United States Supreme Court" from the decision of the Ninth Circuit.**
November, 1998	**Plaintiff's filed Writ of Certiorari with the US Supreme Court to review the lower court's decision.**
December 20, 1998	**OIC filed a brief in response to the Plaintiff's petition in the US Supreme Court.**
January 1999	**US Supreme Court denies Plaintiff's petition for Writ of Certiorari, leaving the decision of the Ninth Circuit Court of Appeals to stand.**

APPENDIX D: Health Professions: Scopes of Practice

Health Profession Scopes of Practice according to the statute regulating to each of the health professions. It should be noted that while the Washington State Department of Health regulates the professions they do not define a scope of practice for the licensed provider. Each profession determines their scope of practice in either the initial licensing process, or in a Sunrise review, both requiring legislative approval.

RCW 18.06.010-Licensed Acupuncture

Definitions.
The following terms in this chapter shall have the meanings set forth in this section unless the context clearly indicates otherwise:
(1) "Acupuncture" means a health care service based on an Oriental system of medical theory utilizing Oriental diagnosis and treatment to promote health and treat organic or functional disorders by treating specific acupuncture points or meridians. Acupuncture includes the following techniques:
(a) Use of acupuncture needles to stimulate acupuncture points and meridians;
(b) Use of electrical, mechanical, or magnetic devices to stimulate acupuncture points and meridians; (c) Moxibustion; (d) Acupressure; (e) Cupping; (f) Dermal friction technique; (g) Infra-red; (h) Sonopuncture; (i) Laserpuncture; (j) Point injection therapy (aquapuncture); and (k) Dietary advice based on Oriental medical theory provided in conjunction with techniques under (a) through (j) of this subsection.

RCW 18.25.005

"Chiropractic" defined.
(1) Chiropractic is the practice of health care that deals with the diagnosis or analysis and care or treatment of the vertebral subluxation complex and its effects, articular dysfunction, and musculoskeletal disorders, all for the restoration and maintenance of health and recognizing the recuperative powers of the body.
(2) Chiropractic treatment or care includes the use of procedures involving spinal adjustments, and extremity manipulation insofar as any such procedure is complementary or preparatory to a chiropractic spinal adjustment. Chiropractic treatment also includes the use of heat, cold, water, exercise, massage, trigger point therapy, dietary advice and recommendation of nutritional supplementation except for medicines of herbal, animal, or botanical origin, the normal regimen and rehabilitation of the patient, first aid, and counseling on hygiene, sanitation, and preventive measures. Chiropractic care also includes such physiological therapeutic procedures as traction and light, but does not include procedures involving the application of sound, diathermy, or electricity.
(3) As part of a chiropractic differential diagnosis, a chiropractor shall perform a physical examination, which may include diagnostic x-rays, to determine the appropriateness of chiropractic care or the need for referral to other health care providers. The chiropractic quality assurance commission shall provide by rule for the type and use of diagnostic and analytical devices and procedures consistent with this chapter.
(4) Chiropractic care shall not include the prescription or dispensing of any medicine or drug, the practice of obstetrics or surgery, the use of x-rays or any other form of radiation for therapeutic purposes, colonic irrigation, or any form of venipuncture.
(5) Nothing in this chapter prohibits or restricts any other practitioner of a "health profession" defined in RCW 18.120.020(4) from performing any functions or procedures the practitioner is licensed or

permitted to perform, and the term "chiropractic" as defined in this chapter shall not prohibit a practitioner licensed under chapter 18.71 RCW from performing medical procedures, except such procedures shall not include the adjustment by hand of any articulation of the spine.

RCW 18.138.010-Dietetics

Definitions.
(1) "Dietetics" is the integration and application of scientific principles of food, nutrition, biochemistry, physiology, management, and behavioral and social sciences in counseling people to achieve and maintain health. Unique functions of dietetics include, but are not limited to:
(a) Assessing individual and community food practices and nutritional status using anthropometric, biochemical, clinical, dietary, and demographic data for clinical, research, and program planning purposes;
(b) Establishing priorities, goals, and objectives that meet nutritional needs and are consistent with available resources and constraints;
(c) Providing nutrition counseling and education as components of preventive, curative, and restorative health care;
(d) Developing, implementing, managing, and evaluating nutrition care systems; and
(e) Evaluating, making changes in, and maintaining appropriate standards of quality in food and nutrition care services.
(2) "General nutrition services" means the counseling and/or educating of groups or individuals in the selection of food to meet normal nutritional needs for health maintenance, which includes, but is not restricted to:
(a) Assessing the nutritional needs of individuals and groups by planning, organizing, coordinating, and evaluating the nutrition components of community health care services;
(b) Supervising, administering, or teaching normal nutrition in colleges, universities, clinics, group care homes, nursing homes, hospitals, private industry, and group meetings.
(3) "Certified dietitian" means any person certified to practice dietetics under this chapter.
(4) "Certified nutritionist" means any person certified to provide general nutrition services under this chapter.
(5) "Department" means the department of health.
(6) "Secretary" means the secretary of health or the secretary's designee.

RCW 18.108.010-Licensed Massage Therapy

Definitions.
In this chapter, unless the context otherwise requires, the following meanings shall apply:
(1) "Board" means the Washington state board of massage.
(2) "Massage" and "massage therapy" mean a health care service involving the external manipulation or pressure of soft tissue for therapeutic purposes. Massage therapy includes techniques such as tapping, compressions, friction, Swedish gymnastics or movements, gliding, kneading, shaking, and facial or connective tissue stretching, with or without the aids of superficial heat, cold, water, lubricants, or salts. Massage therapy does not include diagnosis or attempts to adjust or manipulate any articulations of the body or spine or mobilization of these articulations by the use of a thrusting force, nor does it include genital manipulation.

RCW 18.50.010-Licensed Midwifery

Practicing midwifery defined -- Gratuitous services -- Duty to consult with physician.
Any person shall be regarded as practicing midwifery within the meaning of this chapter who shall render medical aid for a fee or compensation to a woman during prenatal, intrapartum, and postpartum stages or who shall advertise as a midwife by signs, printed cards, or otherwise. Nothing shall be construed in this chapter to prohibit gratuitous services. It shall be the duty of a midwife to consult with a physician whenever there are significant deviations from normal in either the mother or the infant.

RCW 18.71.011-Physican's and Surgeons

Definition of practice of medicine -- Engaging in practice of chiropractic prohibited, when.
A person is practicing medicine if he does one or more of the following:
(1) Offers or undertakes to diagnose, cure, advise or prescribe for any human disease, ailment, injury, infirmity, deformity, pain or other condition, physical or mental, real or imaginary, by any means or instrumentality;
(2) Administers or prescribes drugs or medicinal preparations to be used by any other person;
(3) Severs or penetrates the tissues of human beings;
(4) Uses on cards, books, papers, signs or other written or printed means of giving information to the public, in the conduct of any occupation or profession pertaining to the diagnosis or treatment of human disease or conditions the designation "doctor of medicine", "physician", "surgeon", "m.d." or any combination thereof unless such designation additionally contains the description of another branch of the healing arts for which a person has a license: PROVIDED HOWEVER, That a person licensed under this chapter shall not engage in the practice of chiropractic as defined in RCW 18.25.005.

RCW 18.36A.040-Naturopathic Physician's

Scope of practice.
Naturopathic medicine or naturopathy is the practice by naturopaths of the art and science of the diagnosis, prevention, and treatment of disorders of the body by stimulation or support, or both, of the natural processes of the human body. A naturopath is responsible and accountable to the consumer for the quality of naturopathic care rendered.
The practice of naturopathy includes manual manipulation (mechanotherapy), the prescription, administration, dispensing, and use, except for the treatment of malignancies or neoplastic disease, of nutrition and food science, physical modalities, homeopathy, certain medicines of mineral, animal, and botanical origin, hygiene and immunization, common diagnostic procedures, and suggestion; however, nothing in this chapter shall prohibit consultation and treatment of a patient in concert with a practitioner licensed under chapter 18.57 or 18.71 RCW. No person licensed under this chapter may employ the term "chiropractic" to describe any services provided by a naturopath under this chapter.

APPENDIX E: 1998 Status of Standard Setting in CAM Professions

Current Status of Standard Setting in CAM Professions *(DRAFT)*

Developed by CAM Profession Representatives to the Clinician Workgroup on Integration of CAM, Inter-Association CAM Standards Sharing Forum
Date:January 23, 1998

	Acupuncturists		Chiropractors		Massage Practitioners		Midwives		Naturopaths		Dietitians	
Project	**State Assn.**	**National**	**State**	**National**	**State**	**National**	**State**	**National**	**State**	**National**	**State**	**National**
Code of Ethics	No	No	In process Board returned draft for additional due diligence	Yes	Yes	Yes	Yes Statement of ethic in revision process	Yes	Yes Document: WANP Code of Ethics	Unsure	No State follows national	Yes Enforcement took effect 1989; prior standards in 1982
Peer Review Process	In Process J. Blair, chair	No	No In progress	Unsure	In process	In process	No MAWS once had formal process, but it was voluntary, cumbersome and not protected with immunity	No	Yes In state law (RCW 18.36A); Informal WANP internal process	Unsure	Yes Credentialing Have a review process if something is questionable	Unsure "Procedure for review" document
Managed Care Committee	Yes Carl Dahlgren, Chair	No Some involvement via membership and public affairs committees	Yes 6 members Abt. 6 mtg/yr No staff Budget unknown	Yes	In process Ins. Com. 1/mo No staff No budget	Unsure	Yes Special project of MAWS and Seattle Midwifery School; 4-6 members mtg 4-6/yr part-time paid staff newsletter, info line for members	No Ad hoc group working on this but no official committee	Yes Monthly, B. Milliman, Chair	Yes As needed, J. Booker, Chair	Yes 6 members Meets as needed	Yes 6 members Meets 5/yr Reimbursement team covers MC issues
QA/QI Program	No	No	No Probably not much here, at least at state level	Unsure	No	No	Yes LMs have liability ins. through a Joint Underwriting Agreement (JUA), requires mandatory prof. liability review	No	Yes Document: WANP Co-QIP, 1996	No	No Follows QA/QI developed by ADA	Yes
Standards of Practice	No	No	No Yes, limits on scope	Yes	Yes	Yes	Yes MAWS has statement of conditions requiring phys. consult; law requires consults for some; have avoided written exclusions for particular conditions, leaving room for clinical judgment	Yes, very general	Yes Document: NAC/DOH State Law ("approved standards of practice" guideline) All conditions treated	Yes May not have secured final approval from House of Delegates	No Follows ADA	Yes Passed by House of Delegates in 1984
Medical Records Standards	Yes Dictated by W.A.C.	No	Yes Dictated via W.A.C.	Unsure	Unsure	Unsure	See above MAWS publishes set of charts; widely used, not mandatory	No	Yes Document: Co-QIP, Article VII	Unsure Possibly in Standards of Practice document	No	Yes New form available with the protocols
Offer Standards-Related Seminars	No	Unsure Limited discussion of managed care issues	Yes Most seminars are standards-related	Yes	No	No	Yes CE has included standards, managed care, record keeping	Less so Less standardization at nat'l, or cont. ed.	Yes 1/31-2/1 1998, Document: see WANP brochure and news release		Yes Annual mtg in May	Yes Mtgs in March or October
Practice Guidelines/ Best Practices	No Too many traditions, be a blood bath	No	*See Standards of Practice, above*	*See Standards of Practice, above*	In process	unsure	No Document in #5 sets "when to consult" parameter	No	In Process See National	In Process Funding sought for nat'l effort from Institute of Nat. Medicine	No Follows national	Yes 22 protocols available

APPENDIX F: Cross-Fertilization Questionnaire Responses

Cross-Fertilization Questionnaire Responses

as of 2/26/98

Question	Health Plans	Physician Groups	CAM Assn.
Interest in observing	*n=5 (of 6)*	*n=4 (of 6)*	*n=10 (of 10)*
Personal: CAM Practices	LAc: 2	LAc:	LAc: 2
	LMP: 1	LMP:	LMP: 2
	DC: 1	DC:	DC: 2
	Midwife: 1	Midwife:	Midwife: 1
	ND: 1	ND: 2	ND: 3
	RD:	RD:	RD: 3
Others in Org: CAM practices	YES: 2	YES: 3	YES: 7
	NO: 1	NO:	NO: 1
	Unsure: 2	Unsure: 1	Unsure: 2
Conventional MD/DO	PCP: 1	PCP:	PCP: 2
	Spec:	Spec:	Spec: 6
	Type: *possibly/if time allowed*	Type:	Type: Ortho 4 Neuro 3 Gyn 2 Endo 1 Other 2 DO: 1 PT: 1
Others in Org: MD/DO	YES: 1	YES:	YES: 8
	NO: 1	NO: 1	NO:
Plan Processes	YES: 2	YES:	YES: 9
	NO: 1	NO: 3	NO: 1
If so, what plan processes?	*"My competitors"*		Utilization review 4 Medical necessity 1 Coverage decisions 4 Tech Assessment 1 Benefit design 3 Credentialing 7 QA/QI of all kinds 1 Claims processing 1 Guidelines dev 1 Referral guidelines: 1 Payment levels: 1
Others in Org: Plan Processes	YES: 1	YES:	YES: 7
	NO: 1	NO: 1	NO:
	Possibly: 1	Possibly:	Possibly: 1
Willingness to Be Observed			
By another practitioner	YES: 4	YES: 3	YES: 10
	NO: 1	NO:	NO:
By Plan Rep	YES: 1	YES: 2	YES: 9
	NO: 2	NO:	NO:
	Possibly:	Possibly:	Possibly: 1
Other Members of Org.	YES: 2	YES: 4	YES: 9
	NO: 1	NO:	NO:
	Possibly: 2	Possibly:	Possibly: 1
Providing Small Group Education			
Meet w. CAM providers	YES: 4	YES: 4	YES: 10
Meet with MD/DO	YES:	YES: 1	YES: 10
Polling members	YES: 1	YES: 3	YES: 8
	NO: 2	NO: 1	NO: 1
	Possibly: 3	Possibly:	Possibly: 1

Notes:

- Alternare response put in CAM Assn. column
- Observation of midwives might be limited to prenatal or post-partum care
- One CAM org suggested putting poll in its member newsletter
- "Physician groups" includes all the invited guests to the 2/27 mtg, even if representing a health plan
- One plan says: likes the questionnaire, but no time now; questions should say: *If an opportunity could be created for you, would you make time to do it?*

Some Leading Conditions for Which CAM Professions Believe that Pro-Active Use of their Services will Save Money Under Capitated Contracts

Acupuncturists

Back pain
Digestive complaints
Fibromyalgia
Migraines
Pain

Massage Practitioners

Carpal tunnel/tendonitis
Fibromyalgia
Musculoskeletal problems
Sprains/strains

Chiropractors

Back pain
Neck pain
Headaches

Midwives

Birth

Dietitian/Nutritionists

Kidney/renal failure
heart disease
diabetes
family health (prenatal and pediatric nutrition)

Naturopathic Physicians

Arthritis
Digestive complaints (from constipation to colitis)
Chronic infection (esp. sinusitis and otitis)
Hypertension
Chronic disease
Diverse women's health

Sources:
(1) LA, LMP and NDs: Medalia survey
(2) RD & DC: pre-mtg. response from CWIC participants

APPENDIX G: Plan/Physician Responses: 1998 Plan Coverage Processes

Clinician Workgroup on Integration of CAM (CWIC)

Plan/Physician Responses: Plan Coverage Processes (DRAFT)

All respondents, including plans, provider groups and CAM networks, are listed alphabetically.

Aetna-US Healthcare/NYLCare

Coverage Committee: YES
Name of Committee: Benefits Review Committee
CAM Providers on Committee: NO
Openness to CAM Coverage Requests: YES — Key Contact: Jeffrey Livovich
Utilization Management Committee: YES — Chair: Tim Reitz
Director of UM: YES — Title: Manager, QA
CAM Providers on Committee: NO — Name: --
CAM Committee: NO — Chair: --
CAM Consultants: YES (Carl Dahlgren, LAc)
Offer any "rider" CAM products: NO
Outside parties often used in coverage processes: NO
Have a drug formulary: YES — Chair: Jeffrey Livovich
Past Analysis of CAM Experience
Ever analyzed UM data from CAM experience: YES
Ever surveyed patients on CAM experience: NO
Ever analyzed CAM "add-on versus replacement" issue: NO

Alternare of Washington

Coverage Committee: NO
Name of Committee: -- — Chair: --
CAM Providers on Committee: --
Openness to CAM Coverage Requests: -- — Key Contact: --
Note: A credentialing committee includes reps of all the credentialed professions; chair is Darrell Stewart, President
CAM Committee: -- — Chair: --
CAM Consultants: --
Offer any "rider" CAM products: N.A.
Outside parties often used in coverage processes: N.A.
Have a drug formulary: -- — Chair: --
Past Analysis of CAM Experience
Ever analyzed UM data from CAM experience: Yes, 1997 consumer survey and some analysis based on claims.
Ever surveyed patients on CAM experience: Yes, 1997 survey
Ever analyzed CAM "add-on versus replacement" issue: Two questions in 1997 survey

CAM Solutions

Coverage Committee: YES
Name of Committee: Corporate QA Board — Chair: Eileen Stretch, ND
CAM Providers on Committee: YES
Openness to CAM Coverage Requests: YES — Key Contact: Dr. Stretch
Utilization Management Committee: YES — Chair: Dr. Stretch
Director of UM: NO — Title: --
CAM Providers on Committee: YES
Name(s): Christopher Huson, LAc; Jefferson Saunders, LMP; Christy Lee Engels, ND
CAM Committee: YES — Chair: Dr. Stretch
CAM Consultants: Credentialing Committee includes an ND, LAc, LMP)
Offer any "rider" CAM products: --
Outside parties often used in coverage processes: NO
Have a drug formulary: NO — Chair: --
Past Analysis of CAM Experience
Ever analyzed UM data from CAM experience: "First patients in July, we will be analyzing data"
Ever surveyed patients on CAM experience: "Plan to annually"
Ever analyzed CAM "add-on versus replacement" issue: "We will study this"

Community Health Plan

Coverage Committee: YES
Name of Committee: Benefits Committee Chair: Melicent Whinston, MD
CAM Providers on Committee: NO
Openness to CAM Coverage Requests: YES Key Contact: Kim McClung
Utilization Management Committee: YES Chair: Dr. Whinston
Director of UM: Kim McClung Title: Director of UM/QI
CAM Providers on Committee: NO Name: --
CAM Committee: NO Chair: --
CAM Consultants: "ad hoc basis"
Offer any "rider" CAM products: NO
Outside parties often used in coverage processes: NO
Have a drug formulary: YES Chair: Dr.Whinston
Past Analysis of CAM Experience
Ever analyzed UM data from CAM experience: NO
Ever surveyed patients on CAM experience: NO
Ever analyzed CAM "add-on versus replacement" issue: NO

Group Health Cooperative of Puget Sound

Coverage Committee: NO
Note: GHCPS "Care Management Program" includes clinical pathways development, coordination of care and health review, case management and referral management. "Monitoring and evaluation of hc outcomes, cost and utilization are incorporated in the care management strategies." A key committee is the Clinical Planning and Improvement (CP&I) Council. Others are Delivery System Operating Team and Regional Care management Oversight.
Name of Committee: --
CAM Providers on Committee: --
Openness to CAM Coverage Requests: -- Key Contact:
Utilization Management Committee: YES, several Chair: Asst. VP for CP&I, and Medical Director for CP&I
Director of UM: YES Title:
CAM Providers on Committee: NO Name: --
CAM Committee: NO Chair: --
CAM Consultants: NO
Offer any "rider" CAM products: NO
Outside parties often used in coverage processes: Not for CAM, except perhaps NIH OAM
Have a drug formulary: YES Chair: Jeff Shormick, P&T Committee
Past Analysis of CAM Experience
Ever analyzed UM data from CAM experience: Have pulled some referral data by CAM category
Ever surveyed patients on CAM experience: YES (1994); and some patients have been surveyed by Alternare
Ever analyzed CAM "add-on versus replacement" issue: NO

PacifiCare of Washington

Coverage Committee: YES
Name of Committee: Policies & Procedures Committee Chair: Sharon Carter
CAM Providers on Committee: NO
Openness to CAM Coverage Requests: NO Key Contact: --
Utilization Management Committee: YES Chair: Geoffrey MacPherson, MD
Director of UM: YES Title: Mary Harpster, Director of UM
CAM Providers on Committee: NO Name: --
CAM Committee: NO Chair:
CAM Consultants: --
Offer any "rider" CAM products: NO
Outside parties often used in coverage processes: InterQual, ProWest
Have a drug formulary: YES Chair: (national)
Past Analysis of CAM Experience
Ever analyzed UM data from CAM experience: NO
Ever surveyed patients on CAM experience: NO
Ever analyzed CAM "add-on versus replacement" issue: NO

PREMERA

Coverage Committee: YES Chair: Medical Director
Name of Committee: Health Policy Committee (and others)

CAM Providers on Committee: NO
Openness to CAM Coverage Requests: YES Key Contact: Peter West, MD
Utilization Management Committee: YES Committee: 3 regional Care Management Committees
Director of UM: YES Title: Asst & Assoc Med Director (rotates daily)
CAM Providers on Committee: NO Name: --
CAM Committee: NO Chair: N.A.
CAM Consultants: Via Alternare (ND); several chiropractors
Offer any "rider" CAM products: YES, some groups have different kinds
Outside parties often used in coverage decisions: Not on "decisions"
Have a drug formulary: YES Chair: P&T Committee, PREMERA Med Dir
Past Analysis of CAM Experience
Ever analyzed UM data from CAM experience: YES
Ever surveyed patients on CAM experience: YES, via Alternare
Ever analyzed CAM "add-on versus replacement" issue: report in process

Providence Medical Center

Coverage Committee: --
Decision Maker: David Bare, CFO
CAM Providers on Committee: --
Openness to CAM Coverage Requests: -YES Key Contact: Mr. Bare
Utilization Management Committee: YES Chair: Rayburn S. Lewis, MD
Director of UM: YES Title: Karen Therese, Coordinator
CAM Providers on Committee: NO Name: --
CAM Committee: NO Chair: --
CAM Consultants: James Blair, LAc
Offer any "rider" CAM products: N.A.
Outside parties often used in coverage processes: Providence's own health plan
Have a drug formulary: YES Chair: Paul Anderson., RPh
Past Analysis of CAM Experience
Ever analyzed UM data from CAM experience: NO
Ever surveyed patients on CAM experience: NO
Ever analyzed CAM "add-on versus replacement" issue: NO

Qual Med

Coverage Committee: NO Chair: --
CAM Providers on Committee: NO
Openness to CAM Coverage Requests: NO Key Contact: --
Utilization Management Committee: YES Chair: Art Sprenkle, MD
Director of UM: YES Title: Art Sprenkle, MD, Medical Director
CAM Providers on Committee: NO Name: --
CAM Committee: NO Chair: --
CAM Consultants: --
Offer any "rider" CAM products: YES
Outside parties often used in coverage processes: NO
Have a drug formulary: YES Chair: Art Sprenkle, MD, Chair, P&T Committee
Past Analysis of CAM Experience
Ever analyzed UM data from CAM experience: NO
Ever surveyed patients on CAM experience: NO
Ever analyzed CAM "add-on versus replacement" issue: NO

Regence Blue Shield

Coverage Committee: YES
Name of Committee: Benefits determined by a group's contract; contracts written by Product Development Department; medical policy determined by The Regence Group Medical Advisory Committee, The Regence Group Medical Management Workgroup
CAM Providers on Committee: NO
Openness to CAM Coverage Requests: unsure Key Contact: possibly Marketing Department
Utilization Management Committee: YES Chair: Donald Storey, MD
Note: "UM committee does not make UM decisions. It reviews and approves development and implementation of the program. Medical director and associate medical directors along with licensed professionals and consultant make UM decisions in accord with URAC standards."
Director of UM: YES Title: individual associate medical directors
CAM Providers on Committee: NO Name: --
CAM Committee: YES (ad hoc) Chair: Mark Sollek, MD

CAM Consultants: YES
Offer any "rider" CAM products: YES (DC in some plans)
Outside parties often used in coverage processes: BCBS Association
Have a drug formulary: YES Chair: Debbie Atherly, Formulary director
Note: Atherly is non-voting member of committee of six external members of the Formulary Committee.
Past Analysis of CAM Experience
Ever analyzed UM data from CAM experience: YES (some raw, unaudited data; only detailed on chiropractic)
Ever surveyed patients on CAM experience: NO
Ever analyzed CAM "add-on versus replacement" issue: NO

United Healthcare

Coverage Committee: YES
Name of Committee: On nat'l level a "CAM Interest Group" is discussing benefits and coverage issues
CAM Providers on Committee: YES
Openness to CAM Coverage Requests: -- Key Contact:
Utilization Management Committee: NO Chair:
Director of UM: YES [Debbie Smith Fedon, RN] Title: Manager Medical Management
CAM Providers on Committee: Name:
CAM Committee: YES Chair: Ze'ev Young, MD
CAM Consultants: YES
Offer any "rider" CAM products: YES
Outside parties often used in coverage processes: NO (national committee noted above)
Have a drug formulary: YES Chair: P&T Committee
Past Analysis of CAM Experience
Ever analyzed UM data from CAM experience: NO
Ever surveyed patients on CAM experience: NO
Ever analyzed CAM "add-on versus replacement" issue: NO

University of Washington Physicians

Coverage Committee: YES
Name of Committee: Utilization Management Steering Committee Chair: Patricia C. Temple, MD
CAM Providers on Committee: NO
Openness to CAM Coverage Requests: YES Key Contact: Dr. Temple
Utilization Management Committee: YES Chair: Lynn Kyles, RN, Director, UWP Utilization Management
CAM Providers on Committee: NO Name:
CAM Committee: -- Chair: --
CAM Consultants: --
Offer any "rider" CAM products: --
Outside parties often used in coverage processes: YES, BCWA
Have a drug formulary: YES Chair: Dr. Burkhardt, UWAMC Pharmacy
Past Analysis of CAM Experience
Ever analyzed UM data from CAM experience: YES (# of referrals)
Ever surveyed patients on CAM experience: NO
Ever analyzed CAM "add-on versus replacement" issue: NO

Virginia Mason

Coverage Committee: YES Chair: N.A.
Name of Committee: Using Group Health and other insurer guidelines
CAM Providers on Committee: NO
Openness to CAM Coverage Requests: -- Key Contact:
Utilization Management Committee: YES Chair: Jim Bender, MD
Director of UM: YES Title: Manager Care Medical Director
CAM Providers on Committee: NO Name:
CAM Committee: NO Chair: N.A.
CAM Consultants: --
Offer any "rider" CAM products: N.A.
Outside parties often used in coverage processes: --
Have a drug formulary: YES Chair: P&T Committee, Dr. Stemper, Chair
Past Analysis of CAM Experience
Ever analyzed UM data from CAM experience: NO
Ever surveyed patients on CAM experience: NO
Ever analyzed CAM "add-on versus replacement" issue: NO

APPENDIX H: Integrated Clinic Presentation Questionnaires

CLINICIAN WORKGROUP ON THE INTEGRATION OF CAM
Questions for Integrated Clinic Presentations

Clinic Name Center for Comprehensive Care
Provider Name (completing form) Jim Blair, LAc; Pam Driscoll, BSN
Clinic Address 525 Minor Avenue
Clinic Phone 206-343-2000 Fax 206-624-0766 E-mail jamesblair@compuserve.com

STRUCTURE AND PRACTICE

1. Please describe the business structure of your clinic.
The CCC is an integrated care entity incorporated as an IPO since 1992 and in existence since 1989. Existing businesses within the CCC are self standing as either sole proprietorships or incorporated entities. These businesses are subcontracted by the CCC for the integrated program offerings. Please refer to the CCC handouts for services and providers

2. Please describe the clinical structure of your clinic. The CCC is housed in 10,000 square feet on two floors of a medical building that is adjoined to the First Hill Medical Building and the Minor & James physician group. The floor plan includes an open gym area wrapped
by private treatment rooms, professional and business offices and waiting room. The downstairs portion of the facility has a separate waiting room with private treatment rooms and professional offices. In the rear of the downstairs portion through an adjoining door is located the CCC's staff lounge, Board room and group treatment room. This is the area where the CCC's group treatment programs are conducted.

3. Please describe the management model of your clinic. Individual businesses govern themselves and their practices. The CCC is administrated as a 50%FTE by the Business manager for one of the businesses. This position has had 2 administrators over the life of the CCC.

4. How do the providers in your clinic triage patients? There are multiple licenses and license types at the CCC, some requiring physician referral and others without this requirement. The CCC's Nurse Care Coordinator is the primary avenue for the triaging of patients. When provider to provider referral occurs and there are no requirements for physician intervention then it is usually done on a one to one basis in consultation with the patient.

5. How do your providers communicate when working together on patient treatment plans? Communication is one to one consultation unless there are more than two providers involved. At this time the Nurse Care Coordinator is recruited for continuity and follow through. There are occasional case staffing conferences as time permits for the more difficult cases.

6. Please list the provider license categories that work on your clinic premises. Please refer to the CCC's listing of providers and services handout.

7. Please list the provider license categories that your clinic refers to. The CCC has a wide range of practitioners that are referred to. Suffice it to say that I cannot think of a licensed provider that we do not refer to.

8. How does your clinic refer patients out? We refer out, after patient discussion, by calling the provider or their support staff to whom the referral is being made and follow up with a letter of the treatment regimen to date. We follow up with both the patient and provider where warranted.

9. When do your providers immediately refer out? When there is an acute or emergent condition.

10. Are there patients/conditions that your clinic prefers to treat? XX □ Yes □ No
If yes, describe: Over the past decade the CCC's greatest strength of referral has been in chronic care. A great part of this is due to the nature of the providers housed within and the community that refers to us. Rheumatology and Internal Medicine (pain specialty) have been the most active as they tend have the greatest population of chronically ill patients. Orthopedics and physiatry run a close second in terms of the number of referrals.

11. Are there patients/conditions that your clinic prefers not to treat? XX □ Yes □ No
If yes, describe: Our patient population is diverse.

12. Are there cases that are more appropriate for integrated care? XX □ Yes □ No
If yes, describe: In our experience the chronically ill patient population requires a fully integrated and coordinated care plan if they are to achieve a good quality of life in which they are able to sustain themselves through self care. Independent or stand alone therapy is costly and unable to attain independence form the medical system for this type of patient.

13. Does your clinic see cases that would be described as treatment failures of the conventional system? □ Yes □ No If yes, describe: If one considers system failures to be patients who do not respond within standard modalities and time frames and exceed ability of the third party payor to continue reimbursement, then yes the CCC has a high volume of such patients. We view a certain percentage of this category patient as being a problem of appropriate and timely triaging and stacking of care as opposed to a true integration of services.

14. How many of these do you feel you are able to help? See question #1

15. How many of these are chronic or more needing of behavioral support or intervention? See question #13

ASSESSMENT

1. How does your clinic assess patient satisfaction? We employ a patient satisfaction tool that is included in your CCC packet.

2. How does your clinic assess provider satisfaction? We don't formally assess provider satisfaction. If they leave they aren't happy.....

3. Do you have any patient satisfaction data about integrated services? □Yes □No
If yes, please bring to presentation. Please see the CCC's study on our CFS/FM program presented at the American College of Rheumatology included in the CCC packet of information regarding treatment outcomes.

4. How does your clinic assess patient outcomes? The CCC employs the SF 36, Quality of Life, Beck Depression Inventory, Visual analogue scales and a host of physical and functional assessment tools.

5. How does your clinic handle utilization management? Utilization management is a complex issue as not all providers are covered under any given plan. This issue is taken up by our administrator, nurse care coordinator and appropriate providers. We develop a priority of care, triage through the providers needed in a timely manner, cost it for the patient and become inventive regarding the

patient contact. Inventive here refers to the dovetailing of patient contact and is anywhere from stacking to same time to back-to-back format.

REIMBURSEMENT AND COST

1. Are you consistently reimbursed for CAM services as well as conventional services?
□ Yes □ No Please describe any reimbursement issues you have. The complimentary services are not global enough and many patients, mainly lower income, are unable to access us because of this fact. Sliding scales are used for a limited number of spots. Group treatment models which have proven to be clinically and cost effective are not part of the more global shift attempting to create and environment of cost effective high quality of care.

2. Are the reimbursement issues you have from specific payers?
□ HMOs □ Managed Care Plans □ IPAs □ Others Low reimbursement rates in general. Some payers reimburse at higher rates for same care delivered by adifferent license.

3. Please give us an estimate of the percentage of your clinic business that is:
□ Cash pay ___□ Indemnity ___□ PPO/POS __□ HMO/HCSC _____ □ Other (Please list) The percentages of clinic business is so highly variable with so many different providers that it is difficult to say without a formal in house survey.

4. In your experience are CAM services usually in place of, or in addition to conventional medical services? CAM is the "court of last resort". This is changing over the years as experience teaches us all how to navigate. Formal triaging classes by experienced delivery systems to PCP's still has not been done. Most workshops to date have been introductory.
Please give three examples.

OTHER

1. What efforts are currently underway in quality improvement and data collection? We are doing data collection in our group treatment programs and modifying future care based on those outcomes.

2. Are there ways that our committee could support your work? We have outcomes for CFS and Fibromyalgia (and other chronic programs) that indicate it would cut approximately 60% of cost from standard treatments if the patients receive all the services and still cut costs when the treatment is done □integrated□. The committee can help carry this information for us to the carriers/plans.

3. Have you experienced resistance from the conventional medical community? Resistence does not come from the conventional medical community, we receive resistance from the payers when reimbursement is requested by a patient.

CLINICIAN WORKGROUP ON THE INTEGRATION OF CAM

Questions for Integrated Clinic Presentations

Clinic Name Community Health Centers of King County/Kent Community Health Center
Provider Name (completing form) Thomas Trompeter
Clinic Address 403 East Meeker, Suite 300; Kent, WA 98031
Clinic Phone 425-277-1311Fax 425-277-1566
E-mail chckctt@wolfenet.com

STRUCTURE AND PRACTICE

1. Please describe the business structure of your clinic.
CHCKC is a private non-profit organization with a board of directors that is 51% consumers of CHCKC's services.

2. Please describe the clinical structure of your clinic.
For the Kent CHC:

Physicians:	3
PA-C:	1
ND	2
L.Ac.:	1
Medical Assistants	8

3. Please describe the management model of your clinic.
There is a health center supervisor who is responsible for daily operations; reception staff who handle appointments, check-in and check out; medical records staff; a Russian interpreter; a Client Services Representative who helps providers and patients with referrals and eligibility for various insurance programs

4. How do the providers in your clinic triage patients?
In general, a patient chooses which provider they want to see for their given medical problem. However, there are 10 different conditions which require the initial involvement of a conventional medicine provider. These include conditions such as acute chest pain which could require hospitalization. There is also an active cross-referral pattern between conventional and alternative medicine providers.

5. How do your providers communicate when working together on patient treatment plans?
Providers communicate by reading other provider's notes in the integrated medical record. In addition, providers communicate directly with each other.

6. Please list the provider license categories that work on your clinic premises.
Please see #2 above

7. Please list the provider license categories that your clinic refers to.
Physicians, Midwives, Chiropractic, Massage Therapy.

8. How does your clinic refer patients out?
- Via contract for chiropractic and massage therapy;
- Through hospital affiliation agreements for inpatient care;
- Network contracts for specialty care.

9. When do your providers immediately refer out
Providers immediately refer patients out for problems which are acute and are beyond the scope of primary care family medicine.

10. Are there patients/conditions that your clinic prefers to treat? Yes No
If yes, describe:
Providers treat all problems which fall within their specialties. There are not certain problems which the clinic prefers to treat.

11. Are there patients/conditions that your clinic prefers not to treat? No
If yes, describe:

12. Are there cases that are more appropriate for integrated care? Yes No
If yes, describe:
Yes, but this is very dependent on the patient. For instance, fibromyalgia may respond well to natural medicine alone, or may require the integration of conventional and alternative medicine approaches.

13. Does your clinic see cases that would be described as treatment failures of the conventional system? Yes No If yes, describe:
Yes, but it also sees treatment failures of the alternative medicine system too. Some of the conventional medicine treatment failures tend to be for chronic conditions such as fibromyalgia, recurrent otitis media, chronic pain syndromes, auto-immune disorders, and chronic allergy problems.

14. How many of these do you feel you are able to help?
Most patients are helped in some way to varying degrees.

15. How many of these are chronic or more needing of behavioral support or intervention?
A majority of patients with chronic conditions, have illnesses which are influenced by a mind-body connection. Some of these respond to behavioral support. Other patients do well with lifestyle changes including the addition of exercise, yoga, and even meditation.

ASSESSMENT

1. How does your clinic assess patient satisfaction?
We conduct annual patient satisfaction surveys; monitor daily performance via "How Are We Doing?" questionnaires distributed in the clinic's waiting area; and participate in various customer service research via our involvement with our managed care plan.

2. How does your clinic assess provider satisfaction?
We conduct semi-annual staff satisfaction surveys and convene monthly provider meetings.

3. Do you have any patient satisfaction data about integrated services? Yes No
If yes, please bring to presentation.
We don't have data specifically broken out for patients who use natural medicine services.

4. How does your clinic assess patient outcomes?
Through monitoring of clinical data. Some data are pulled directly from our MIS; other data are gathered through sampling charts.

5. How does your clinic handle utilization management?
Within the Kent CHC, patients may self-refer to either the Naturopathic Physicians or the Licensed Acupuncturist. For our corporation, quality and utilization are managed via a formal, state-approved Quality Improvement and Utilization Management plan.

REIMBURSEMENT AND COST

1. Are you consistently reimbursed for CAM services as well as conventional services?
No. There are limits to insurance coverage which include limits on the number of visits a patient may have in a certain time period and limits on total expense per patient (normally $500 per year). There are also stringent referral policies that limit patient access and provider reimbursement.

2. Are the reimbursement issues you have from specific payers?
We find these issues most commonly among IPAs and other indemnity plans. With HMOs and Plans, things are fairly straightforward.

3. Please give us an estimate of the percentage of your clinic business that is:

Cash pay 60%
Indemnity: 10%
PPO/POS: 10%
HMO/HCSC 20%

Other (Please list) CHCKC sees many Medicaid and Medicare patients for whom these services are not covered.

4. In your experience are CAM services usually in place of, or in addition to conventional medical services?
By virtue of the nature of our clinic, CAM and conventional services are provided in an integrated environment, with cross-consultation by providers and free self-referral back and forth.

OTHER

1. What efforts are currently underway in quality improvement and data collection?
CHCKC participates in a variety of quality improvement activities, both internal to CHCKC and in collaboration with other health centers in the Seattle area.

2. Are there ways that our committee could support your work?
I don't know – let's discuss.

3. Have you experienced resistance from the conventional medical community?
Only when the clinic was initially established, and then not significantly. We now receive inquiries from across the country and across provider groups about how we have constructed integrated services.

CLINICIAN WORKGROUP ON THE INTEGRATION OF CAM

Questions for Integrated Clinic Presentations

Clinic Name Harborview Medical Center
Provider Name (completing form) Heidi Sitton, RN
Clinic Address 325 9th Avenue, Seattle, WA 98104
Clinic Phone 206-731-3111 Fax206-731-8526 E-mail hcsitton@u.washington.edu

STRUCTURE AND PRACTICE

1. Please describe the business structure of your clinic. University of Washington

2. Please describe the clinical structure of your clinic. Reception, assessment by counselor as needed, acupuncture or massage therapist would establish treatment plan based on the referral. Staffed by NAIOM and Brenneke-clinical faculty supervisors and students. Counselor, PHd.

3. Please describe the management model of your clinic. 1)Medical Director, 2)Practice Manager, 3)Clinical Supervisor.

4. How do the providers in your clinic triage patients? All patients are referral based. Triaging for scheduling appointments sooner then next available is done by RN supervisor. Level of pain.

5. How do your providers communicate when working together on patient treatment plans? Patient satisfaction surveys, dictated consult notes, team meetings among providers in clinic.

6. Please list the provider license categories that work on your clinic premises. RN, LMP, PhD, LAc

7. Please list the provider license categories that your clinic refers to.

8. How does your clinic refer patients out?

9. When do your providers immediately refer out?

10. Are there patients/conditions that your clinic prefers to treat? XX☐ Yes ☐ No
If yes, describe: chronic pain

11. Are there patients/conditions that your clinic prefers not to treat? XX ☐ Yes ☐ No
If yes, describe:

12. Are there cases that are more appropriate for integrated care? ☐ Yes ☐ No
If yes, describe:

13. Does your clinic see cases that would be described as treatment failures of the conventional system? XX☐ Yes ☐ No If yes, describe: Intractable pain not relieved with narcotics, chronic pain seeking relief other than narcotics or conventional methods.

14. How many of these do you feel you are able to help? Unable to assess-clinic just opened 1/99-too early to tell.

15. How many of these are chronic or more needing of behavioral support or intervention? Same as above. We are trying to have all new referrals assessed by counselor prior to acupuncture or massage therapy.

ASSESSMENT

1. How does your clinic assess patient satisfaction?

2. How does your clinic assess provider satisfaction?

3. Do you have any patient satisfaction data about integrated services? XX□Yes □No
If yes, please bring to presentation.

4. How does your clinic assess patient outcomes?

5. How does your clinic handle utilization management?

REIMBURSEMENT AND COST

1. Are you consistently reimbursed for CAM services as well as conventional services?
□ Yes XX□ No Please describe any reimbursement issues you have. The majority of HMC patients are DSHS/Basic Health patients & DSHS does not reimburse for CAM services.

2. Are the reimbursement issues you have from specific payers?
□ HMOs □ Managed Care Plans □ IPAs XX□ Others DSHS

3. Please give us an estimate of the percentage of your clinic business that is:
□ Cash pay _____ □ Indemnity _____ □ PPO/POS _____ □ HMO/HCSC _____
XX□ Other (Please list) DSHS.

4. In your experience are CAM services usually in place of, or in addition to conventional medical services? In addition to conventional.
Please give three examples. 1) Narcotics as needed with acupuncture 1x ea week. 2) NSAIDS as needed/routine with acupuncture 1x ea week. 3) muscle relaxants as needed with massage therapy 1x ea week.

OTHER

1. What efforts are currently underway in quality improvement and data collection?

2. Are there ways that our committee could support your work?

3. Have you experienced resistance from the conventional medical community? Very political environment at HMC/teaching community/ environment.

CLINICIAN WORKGROUP ON THE INTEGRATION OF CAM
Questions for Integrated Clinic Presentations

Clinic Name: Puget Sound Birth Center, P.S.
Provider Name (completing form): LeeAnne Shelley, LM
Clinic Address: 13128 Totem Lake Blvd NE Suite 101 Kirkland, WA 98034
Clinic Phone: 425-823-1919 Fax: 425-823-7037
E-mail: LeeAnne_Shelley@MSN.com

STRUCTURE AND PRACTICE

1. Please describe the business structure of your clinic. Puget Sound Birth Center is a professional services corporation, Sub S. I am the sole share holder and officer of the corporation.

2. Please describe the clinical structure of your clinic. The birth center has two basic clinical functions: 1. The facility provides a licensed facility in which community midwives can provide intrapartum 2. It provides midwifery care for clients during the prenatal intrapartum and postpartum cycle. Two midwives share clients 50/50

3. Please describe the management model of your clinic. The president / Administrator over sees policy and program development, manages the midwives and employees. One of the midwives oversees the Q.A. programs

4. How do the providers in your clinic triage patients? All client calls & inquiries are directed to the midwife on call via the receptionist during business hours. After hours, the answering service receives the call and pages the midwife on call. The midwife returns the call within 15 minutes.

5. How do your providers communicate when working together on patient treatment plans? We have agreed upon standard treatment plans and pro active guidelines. One midwife charts very clearly her interaction with the client along with the treatment plan. Weekly on Tuesday we pass call by reviewing any cases for which there are on going issues. The midwife writing up the plan does the follow through if that is indicated.

6. Please list the provider license categories that work on your clinic premises. Licensed Midwives, Certified Nurse Midwives, Licensed Massage Therapists.

7. Please list the provider license categories that your clinic refers to. Medical Doctors: Perinatologists, Neonatologist, Pediatricians, Obstetricians, Family Practice, Chiropractors, Naturopathic Doctors, Acupuncturists, Massage Therapists, Psycho Therapist and Radiologists.

8. How does your clinic refer patients out? Either the midwife personally calls the professional or writes a consultation / referral request including pertinent clinical information

9. When do your providers immediately refer out? When the care of a different provider is needed in a time sensitive fashion. I.e. a client who is developing PIH.

10. Are there patients/conditions that your clinic prefers to treat? Yes No
If yes, describe: Patients who want to participate in the care and to assume their responsibility

11. Are there patients/conditions that your clinic prefers not to treat? Yes No
If yes, describe: Patients who abdicate responsibility for their health

12. Are there cases that are more appropriate for integrated care? Yes No
If yes, describe:

13. Does your clinic see cases that would be described as treatment failures of the conventional system? Yes No If yes, describe: We often get patients whose first births were subjected to active management instrumental delivery and separation from baby at birth. They were often prematurely induced before they were truly post dates.

14. How many of these do you feel you are able to help?95%

15. How many of these are chronic or more needing of behavioral support or intervention?5%

ASSESSMENT

1. How does your clinic assess patient satisfaction? Referrals, Thankyou's Cards, Birthday invitations, Volunteerism, Exit Interviews, All our appts are one hour long. There is a lot of dialogue. An atmosphere almost always exists for honest communicated problem solving. And extraordinary amount of trust is built.

2. How does your clinic assess provider satisfaction? Not officially. We have weekly staff meetings in which we address issues brought up by the staff and providers

3. Do you have any patient satisfaction data about integrated services? Yes No If yes, please bring to presentation.

4. How does your clinic assess patient outcomes? Data Collection

5. How does your clinic handle utilization management? I am not sure this applies. In our case, the client either has maternity coverage or not.

REIMBURSEMENT AND COST

1. Are you consistently reimbursed for CAM services as well as conventional services?
Yes No Please describe any reimbursement issues you have. Intrapartum care (the care that parallels the nursing care patients receive with the hospital doing the labor and postpartum care) frequently does not get paid

2. Are the reimbursement issues you have from specific payers?
HMOs Managed Care Plans IPAs Others ALL

3. Please give us an estimate of the percentage of your clinic business that is:
Cash pay 2% Indemnity 0% PPO/POS 58%_ HMO/HCSC 15%
Other (Please list) DSHS or Healthy Options 25%

4. In your experience are CAM services usually in place of, or in addition to, conventional medical services? In place of.
Please give three examples. 1. Chiropractic (exclusively) for low back or sciatic pain. 2. Naturopathic for viral infection. 3. Herbalist for sinus infection

OTHER

1. What efforts are currently underway in quality improvement and data collection? We are yearly reviewed by an outside professional quality improvement professional. We also are reviewed yearly by a state appointed facility reviewer. We are in the process of developing regular in services for privileged midwives.

2. Are there ways that our committee could support your work? It would be helpful to have dialogue with the insurance carriers to assist them in better understanding the midwifery model of care. It would be helpful to have them understand how our intrapartum care parallels the intrapartum nursing care in the hospital; this would hopefully encourage them to pay our intrapartum fees.

3. Have you experienced resistance from the conventional medical community? Historically yes. However, there is less resistance from hospitals and some OB's in more recent years.

CLINICIAN WORKGROUP ON THE INTEGRATION OF CAM
Questions for Integrated Clinic Presentations

Clinic Name Seattle Cancer Treatment and Wellness Center
Provider Name (completing form) Patrick Donovan, ND and Kim Carlson, Administrator
Clinic Address 901 Boren Avenue, Seattle, WA 98104
Clinic Phone 206-292-2277 Fax 206-292-2015 E-mail

STRUCTURE AND PRACTICE

1. Please describe the business structure of your clinic. Medical Oncology and wellness clinic.

2. Please describe the clinical structure of your clinic. Complementary oncology combination of medical oncology, naturopathic medicine, western chinese medicine and acupunture, and dietetics.

3. Please describe the management model of your clinic. Independent oncology practice affiliate with Cancer Treatment Centers of America.

4. How do the providers in your clinic triage patients? 1) Practitioner requested at scheduling, 2) reason for scheduling i.e., second opinion from oncologist, primary oncology evaluation/care, naturopathic care, nutritional or oriental med consult. 3) degree of pathology/illness and/or intervention needed.

5. How do your providers communicate when working together on patient treatment plans? Weekly scheduled AM provider meetings, daily unscheduled provider meetings, on-the-spot provider communications, scheduled joint office visits with patient, phone calls.

6. Please list the provider license categories that work on your clinic premises. Provider licenses include: MD (Internal medicine and Oncology), ND, LAc, OMD, RN, MS, RD

7. Please list the provider license categories that your clinic refers to. Referral providers include all of in question #6, any appropriate specialties (MD, DO) and Ph.D./MSW therapists.

8. How does your clinic refer patients out? Patients are referred out by: 1) determining the need for medical evaluation/treatment of patient that SCTWC providers are not capable of providing, 2) calling and discussing patient with referral target/professional, 3) informing patient 4) informing front desk staff so that referral coverage can be assured, 5) informing insurance carrier as needed.

9. When do your providers immediately refer out? Immediate referrals are made when providers determine immediate needs of patient providers are not capable of providing.

10. Are there patients/conditions that your clinic prefers to treat? XX☐ Yes ☐ No
If yes, describe: Our clinic prefers to treat patients who have or have had a history of cancer and who are in need of treatment or preventive follow-up care.

11. Are there patients/conditions that your clinic prefers not to treat? ☐ Yes ☐ No
If yes, describe: Our clinic prefers not to treat medical/surgical emergencies; and primary pediatric, obstetric, opthalmologic, orthopedic and psychiatric disorders.

12. Are there cases that are more appropriate for integrated care? □ Yes □ No
If yes, describe: There are numerous cases that are more appropriate for integrated care. Some of these include: various neoplasia, gastrointestinal-associated disorders, autoimmune and chronic inflammatory/rheumatologic disorders, hypertension and cardiovascular disease, osteoporosis, PMS and menopausal-related complaints.

13. Does your clinic see cases that would be described as treatment failures of the conventional system? XX□ Yes □ No If yes, describe: We often see treatment failures of the conventional system. Most often, due to the nature of our practice, we see patients who have failed conventional cancer treatments. Not commonly but at times we see patients that were not fully evaluated for their primary illness and/or were misdiagnosed.

14. How many of these do you feel you are able to help? It is hard to put accurate numbers to it but we have helped nearly every cancer patient who has failed conventional care well outlive their conventional death proclamation with much greater quality of life.

15. How many of these are chronic or more needing of behavioral support or intervention? It is safe to say that all the patients we see with cancer and other chronic diseases are in need of psychological/emotional/spiritual care and intervention as is their immediate families in most cases.

ASSESSMENT

1. How does your clinic assess patient satisfaction? Through patient satisfaction surveys.

2. How does your clinic assess provider satisfaction? Also through patient satisfaction surveys.

3. Do you have any patient satisfaction data about integrated services? □Yes XX□No
If yes, please bring to presentation.

4. How does your clinic assess patient outcomes? We have no formal assessment tool(s) in place at this time. Our primary tool(s) is the patient□s chart (scans, lab work, diagnostic reports, exams, patient reports etc.) And the patient□s subjective reports and satisfaction.

5. How does your clinic handle utilization management? The MD or RN call for approvals.

REIMBURSEMENT AND COST

1. Are you consistently reimbursed for CAM services as well as conventional services?
□ Yes □ No Please describe any reimbursement issues you have. Provider numbers pending.

2. Are the reimbursement issues you have from specific payers?
□ HMOs □ Managed Care Plans □ IPAs □ Others

3. Please give us an estimate of the percentage of your clinic business that is:
□ Cash pay 5% □ Indemnity 10% □ PPO/POS 65% □ HMO/HCSC 10%
□ Other (Please list) miscellaneous insurance

4. In your experience are CAM services usually in place of, or in addition to conventional medical services?
Please give three examples.

OTHER

1. What efforts are currently underway in quality improvement and data collection? Quality of life data collection.

2. Are there ways that our committee could support your work? Not at this time.

3. Have you experienced resistance from the conventional medical community? We experienced the expected resistance from the conventional oncological community in the beginning but can gladly report that there is consistently increasing open communications, information exchange, inclusion in professional seminars and patient referrals coming from that community.

CLINICIAN WORKGROUP ON THE INTEGRATION OF CAM

Questions for Integrated Clinic Presentations

Clinic Name: Seattle Healing Arts
Provider Name (completing form): Bruce Milliman, ND; Fernando Vega, MD
Clinic Address: 420 NE Ravenna Boulevard, Seattle, WA 98115
Clinic Phone: 206-524-5054 Fax: 206-522-5646
E-mail: doctorwbm@earthlink.net

STRUCTURE AND PRACTICE

1. Please describe the business structure of your clinic. Individual (sole) practitioners; joint booking, phones, advertising and billing. Some (most) practitioners rent space only, with no added purchased services.

2. Please describe the clinical structure of your clinic. Patients book with individual practitioners; in and out of office referrals take place.

3. Please describe the management model of your clinic. Office manager oversees all.

4. How do the providers in your clinic triage patients? Individual doctors function as decision makers; MA□s do some phone triage..

5. How do your providers communicate when working together on patient treatment plans? Shared office space- all desks, books, phones, viewing screened in office. Docs cross over into each other□s exam rooms for consulting on cases presented extemporaneously

6. Please list the provider license categories that work on your clinic premises. MD, ND, LAc, CMHC, LMP, MSW

7. Please list the provider license categories that your clinic refers to. MD, ND, LAc, CMHC, PT, OD, DO, LMP, DC

8. How does your clinic refer patients out? Called, written and given (like Rx) Faxed , mailed.

9. When do your providers immediately refer out? Cancer (especially leukemia) and profound anemia of unknown origin; for imaging, surgery (general, specialist).

10. Are there patients/conditions that your clinic prefers to treat? □ Yes □ No
If yes, describe: All primary care conditions (not requiring sustained care).

11. Are there patients/conditions that your clinic prefers not to treat? □ Yes XX□ No
If yes, describe: Not generally-maybe certain individuals who abuse □the system□.

12. Are there cases that are more appropriate for integrated care? XX □ Yes □ No
If yes, describe: Conventional medical treatment failures, where medications cause unacceptable side effects, or where philosophical injunction to □medical□ intervention prevails.

13. Does your clinic see cases that would be described as treatment failures of the

conventional system? XX□ Yes □ No If yes, describe: Including diagnosis failures. (Where basic labs are not done-this is a diagnosis failure); simultaneously with H. Pylori, Gastritis, Hypothyroidism, Anemia□s, Malnutrition, Fatigue, Chronic sinusitis, otitis, psoriasis, acne, eczema, arthritis, hypertension, allergy□s.

14. How many of these do you feel you are able to help? Many

15. How many of these are chronic or more needing of behavioral support or intervention? Most of the cases are chronic. Some of the cases are more needing of behavioral support.

ASSESSMENT

1. How does your clinic assess patient satisfaction? By the number of patients that return.

2. How does your clinic assess provider satisfaction? Weekly meetings.

3. Do you have any patient satisfaction data about integrated services? □Yes XX□No
If yes, please bring to presentation.

4. How does your clinic assess patient outcomes? Progress notes tell the story.

5. How does your clinic handle utilization management? With considerable energy expenditure, discussion between clinicians-mainly, utilization drops off when patients get better.

REIMBURSEMENT AND COST

1. Are you consistently reimbursed for CAM services as well as conventional services?
XX□ Yes □ No Please describe any reimbursement issues you have. Slow in some cases; large write-off□s, excessive paperwork requirements, the usual complaint of all providers.

2. Are the reimbursement issues you have from specific payers?
□ HMOs □ Managed Care Plans □ IPAs □ Others Yes, all of them equally.

3. Please give us an estimate of the percentage of your clinic business that is:
□ Cash pay 10% Indemnity <5% □ PPO/POS >30% HMO/HCSC >50%
□ Other (Please list)

4. In your experience are CAM services usually in place of, or in addition to conventional medical services? Usually in place of, occasionally in addition.
Please give three examples. In place of: Otitis Media, sinusitis, arthritis, depression, CHF, many of the male and female reproductive issues.
In conjunction with: Asthma (may use fewer steroids), hypertension (usually transitional to allow needed permanent changes to □kick in□).

OTHER

1. What efforts are currently underway in quality improvement and data collection? None started in house.

2. Are there ways that our committee could support your work? Unsure.

3. Have you experienced resistance from the conventional medical community? Some in discussion groups-not much in personal clinical interactions.

APPENDIX I: Draft Seed Algorithms

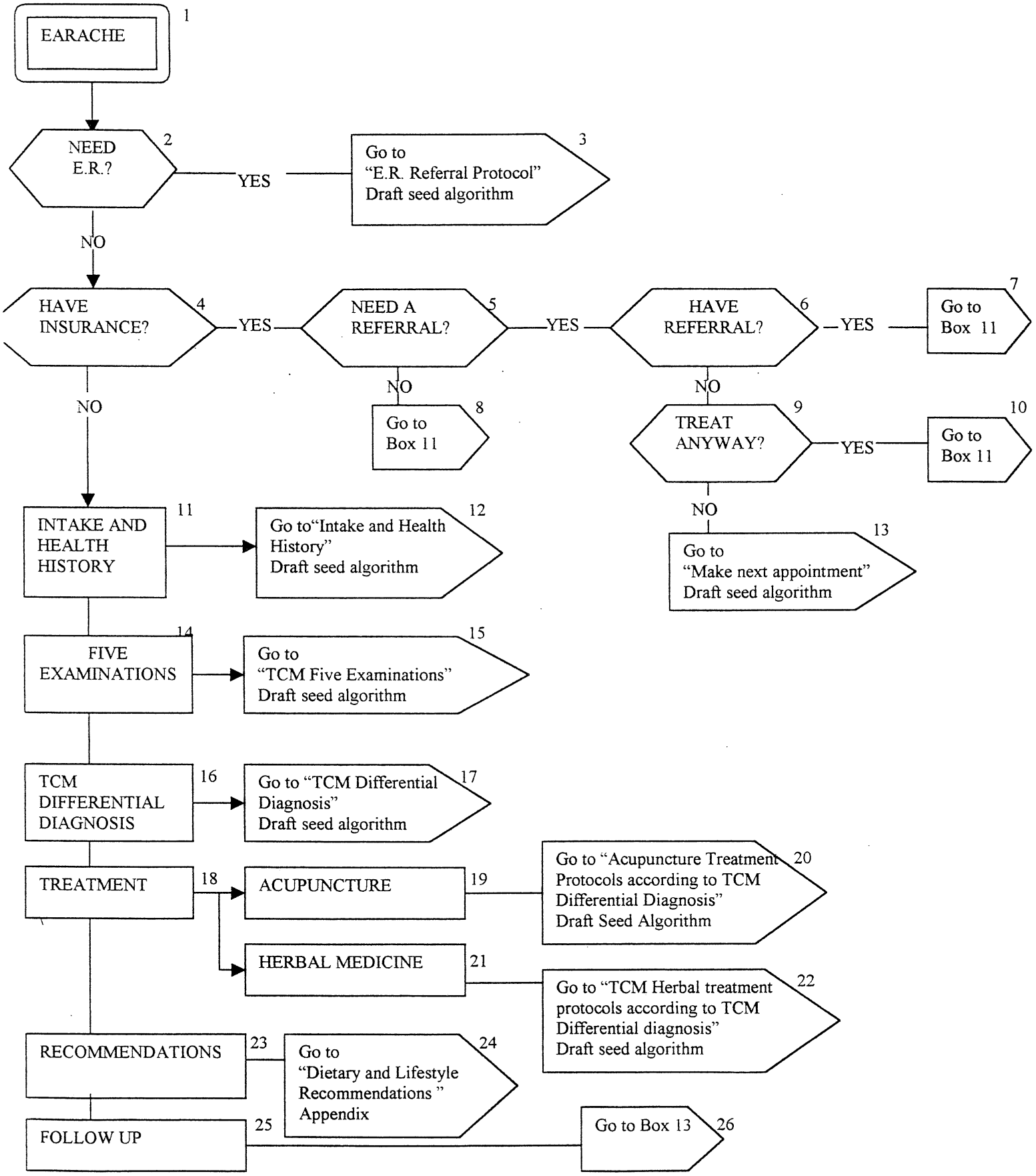
The insurable practice descriptions and draft seed algorithms here reflect examples of care pathways developed, considered, and/or used by various participants during the CWIC process. They only represent examples intended to clarify relationships among conditions and to identify potential clinical thresholds and decision points. These draft pathways have not been approved, endorsed or recommended by the Office of the Insurance Commissioner, any CWIC participant organization nor any individual members, staff, facilitators, or consultants associated with CWIC.

The preliminary draft-seed nature of the examples included here is emphasized. Although many have been developed by groups of CAM providers and representatives of provider organizations or institutions, they have not been tested, implemented, refined or subjected to other means of peer scrutiny and validity testing.

Seed algorithms are not diagnostic or treatment standards for individual patients, and the ones presented here are not intended as definitive. Rather, they serve as examples of the kinds of thought processes practitioners and patients might commonly consider. They may be of interest in providing a framework for considerations regarding care of patients in situations characterized by them. They are not intended to replace the practitioner's clinical judgement nor do they establish a protocol for diagnosis and treatment of patients with any particular set of symptoms. Further, their inclusion here is not implied for use as benchmarks for standards of care or utilization review purposes.

A Draft Seed Algorithm for
The Management of Pediatric Otitis Media with Traditional Chinese Medicine(TCM)

Respectfully submitted to the CWICAM by the AAW 10/28/99



Notes for ***Draft Seed Algorithm: Management of (Western Diagnosis) Otitis Media with Traditional Chinese Medicine (TCM)***

A) Box 12: Intake and Health History

"Intake and Health History Protocol", American Complimentary Care Network (ACCN) Provider Handbook 1999 for Acupuncture Providers, Minneapolis, Minnesota

B) Box 15: TCM Five Examinations

Five Examinations: 1.Looking; 2. Listening/Smelling; 3. Feeling; 4. Pulse Examination 5. Questioning
From
Pp. 15-27 " A Handbook of TCM Pediatrics " Bob Flaws, 1997 Blue Poppy Press, Boulder Colorado

C) Box 17: TCM Differential Diagnosis

Syndromes:
- 1) Acute type: a. External Cause
  - 1. Wind heat
  - 2. Wind Heat with Damp
  - 3. Wind-cold
  - 4. Wind Cold with damp
- b. Internal Cause
  - 1. Liver / Gallbladder heat
  - 2. Liver / Gallbladder heat with damp
- 2) Chronic Type
  - 1. Lingering Pathogenic Factor
  - 2. Spleen Deficiency
  - 3. Liver and Kidney Yin Deficiency

from:

pp 1-46 Volume 1, Module v, Lesson 3 " Acupuncture for Children " 1996 Julian Scott & Teresa Barlow

D) Box 20: Acupuncture Treatment protocols

Pp 25 – 28, 43-45 Volume 1, Module v, Lesson 3 " Acupuncture for Children " 1996 Julian Scott & Teresa Barlow

E) Box 22: Herbal Treatment protocols

Pp 127-138 " A Handbook of TCM Pediatrics " Bob Flaws, 1997 Blue Poppy Press, Boulder Colorado

F) Box 24: Recommendations

Pp 13-15, 29,35, 43-46, Volume 1, Module v, Lesson 3 " Acupuncture for Children " 1996 Julian Scott & Teresa Barlow

Washington State Chiropractic Association
Report for the Clinician Workgroup on Integration of CAM
Introduction, Fall 1999

This report is intended exclusively for the use of CWIC committee. It is not to be used as a guideline document or as a template for utilization review. The data and algorithms are not endorsed or currently utilized by the membership of WSCA. This report is another step in developing a better understanding about chiropractic health care between the members of the CWIC committee.

Utilization ranges, practice trends, demographics, procedures, conditions and activities presented in this report are derived from national surveys and interviews of chiropractors. The information may not reflect local practice patterns because the State of Washington chiropractic laws and rules are unique. The algorithms are examples from the book "Differential Diagnosis for the Chiropractor" by Dr. Souza published by Aspen Publication. However, Dr. Souza's book is not widely used by local chiropractors.

Utilization range data is organized by severity for the case rather than by condition because of the lack of condition based data. Practice trends indicate the caseload of chiropractors has been stable for the past 20 years. Chiropractors are mostly white males while chiropractic patients are mostly white females. Most Chiropractors utilize full spine adjusting techniques and many utilize supportive therapies. Spinal subluxation and spinal joint dysfunction are the routine conditions chiropractors deal with. Spinal subluxation and spinal joint dysfunction are routinely accompanied by spinal pain and/or headache and frequently by neuralgia/radiculopathy.

Chiropractic activities routinely include initial case history, S.O.A.P notes, physical examination, orthopedic/neurological examination, specific chiropractic examination, forming a diagnosis, determining case management, performing adjusting techniques, evaluating the patient's condition, updating the chiropractic examination, modifying case management and encouraging the patients to change habits/lifestyle. Chiropractors frequently take x-rays, perform supportive procedures, discuss care alternatives with patients and recommend/arrange other services.

Algorithm development and use is just emerging in the chiropractic profession. The algorithms used in this report are not specific to Washington State (chiropractors do not perform any invasive procedures in Washington State). The WSCA is interested in developing local guidelines, algorithms and credentialling recommendations. In addition the WSCA would like to begin gathering condition based utilization data in an effort to better understand the cost/risk/benefit of condition based chiropractic care. While most chiropractors remain committed to wellness health care, the WSCA recognizes the need to define the acute/curative portion of chiropractic care that is billable to government, insurance and business payers.

Chiropractic Care Utilization Ranges

Mild Case	**Moderate Case**	**Severe Case**
(50% of Chiropractic Cases) Mild Pain ROM Problems 1-90 Days 1-4 Exams 0-1 Sets X-rays 1-20 Adjustments/Manipulations 0-15 Modalities Subluxation & Pain Codes $100-$500 90% Success	(40% of Chiropractic Cases) Limited Pain ROM/Muscle Problems 60-180 Days 3-7 Exams 1-2 Sets of X-rays 10-40 Adjustments/Manipulations 0-20 Modalities Subluxation, Pain & Joint/Nerve/Muscle Inflammatory Codes $300-$1000 60% Success	(10% of Chiropractic Cases) Significant Pain ROM/Muscle/Neuro Problems 90-360 Days 4-13 Exams 1-3 Sets of X-rays 30-80 Adjustments/Manipulations 0-30 Modalities Subluxation, Pain & Degenerative/Post Operative Codes $500-$2000 30% Success

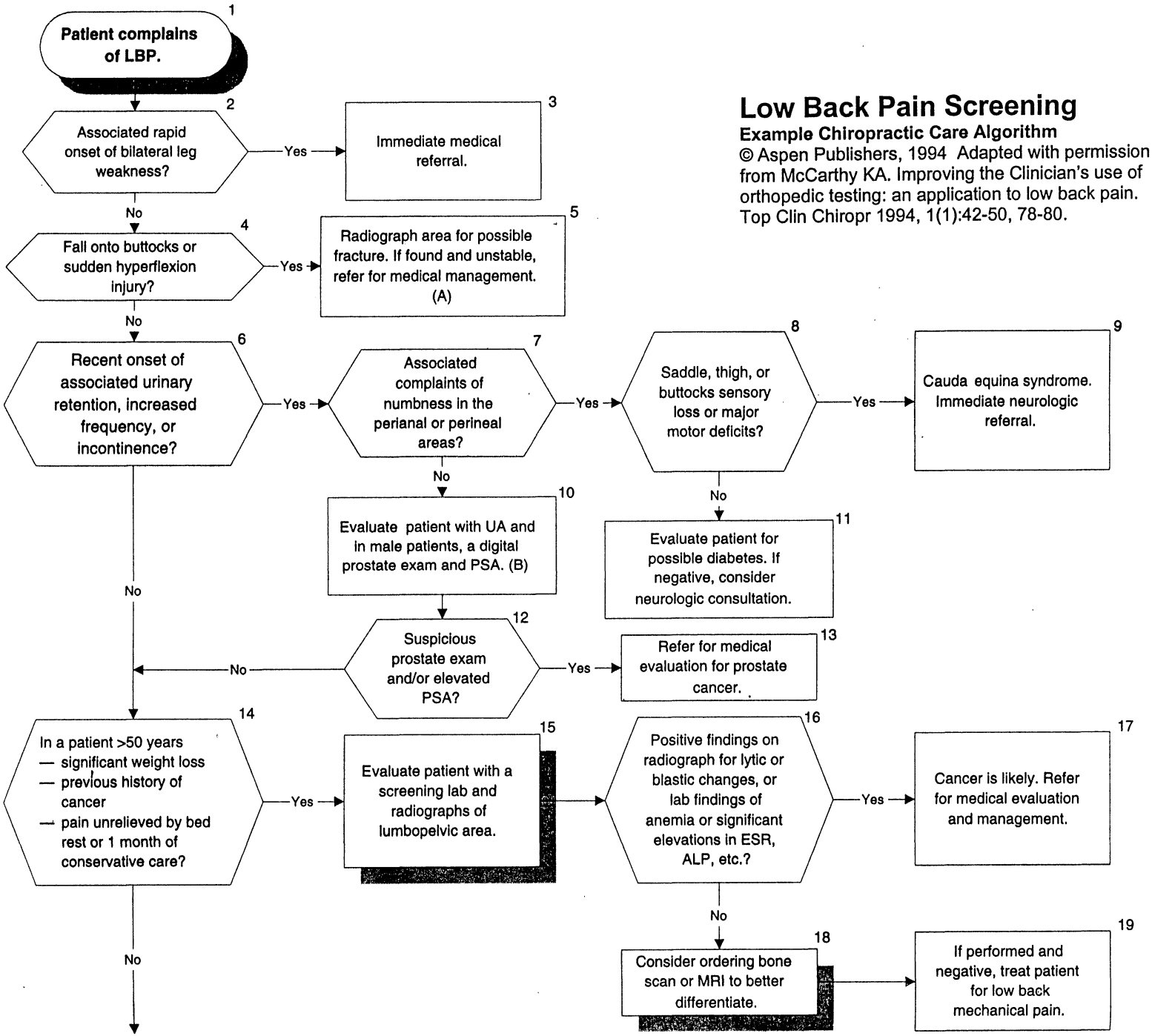
Average Cost Breakdown

- 25% Diagnostics
- 25% Supportive
- 50% Adjustments/Manipulation
- $50/Encounter ($40-$90 range)

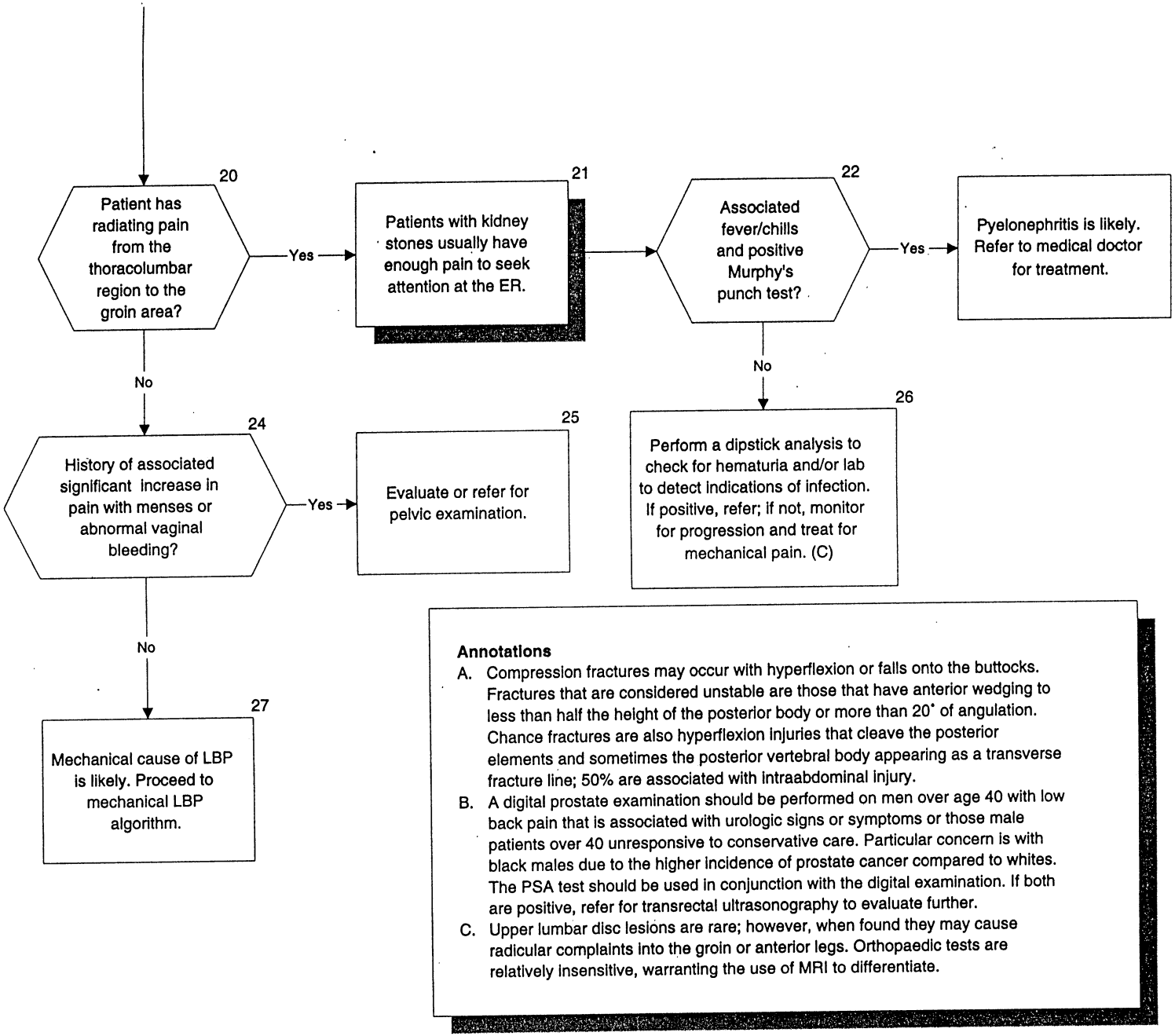
Primary Symptom Breakdown: 80% NMS 20% Systemic

Low Back Pain Screening

Example Chiropractic Care Algorithm



continues

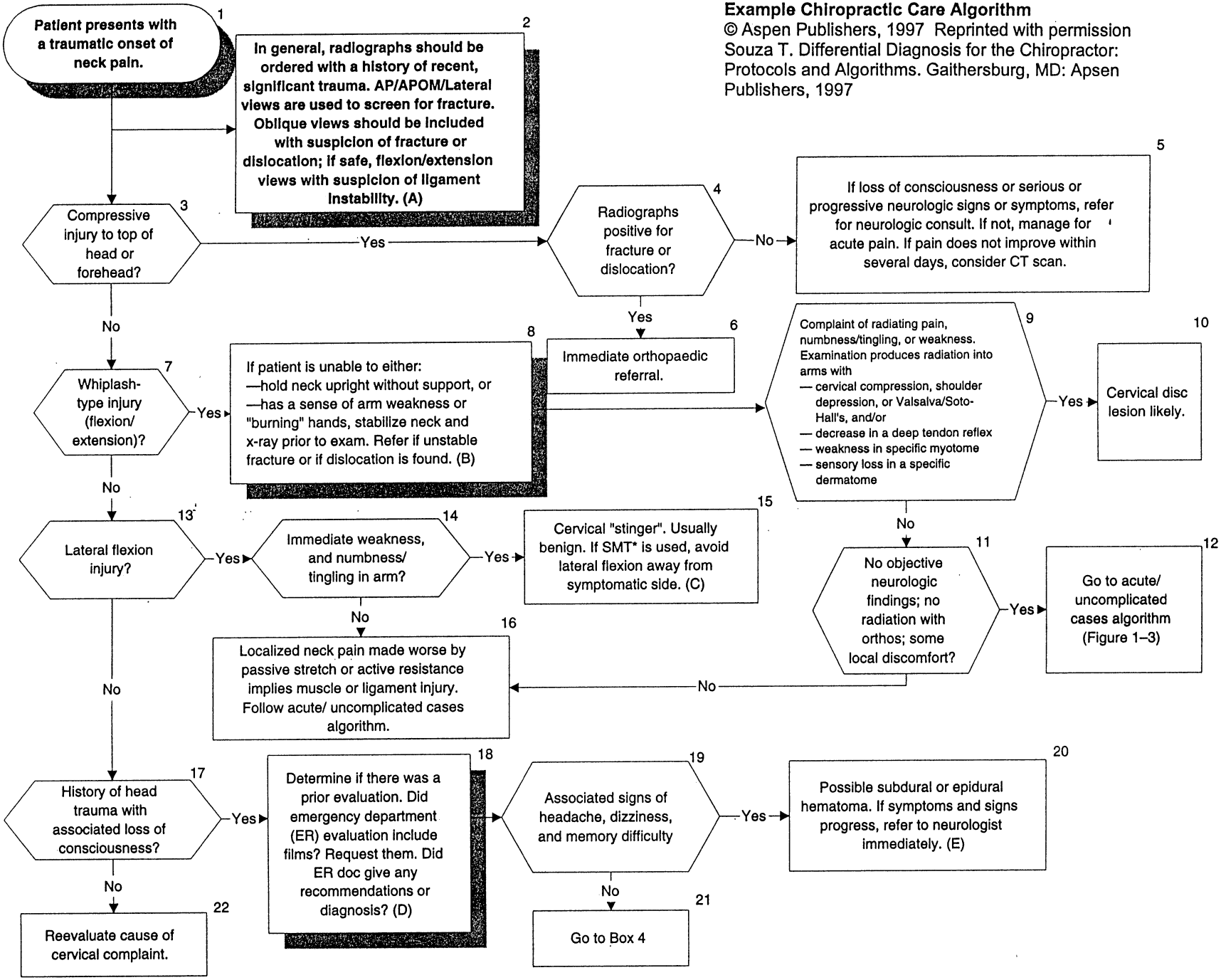


Key: UA, urinalysis; PSA, prostate-specific antigen; ESR, erythrocyte sedimentation rate; ALP, alkaline phosphatase.

Traumatic Neck Pain

Example Chiropractic Care Algorithm

Souza T. Differential Diagnosis for the Chiropractor: Protocols and Algorithms. Gaithersburg, MD: Apsen Publishers, 1997

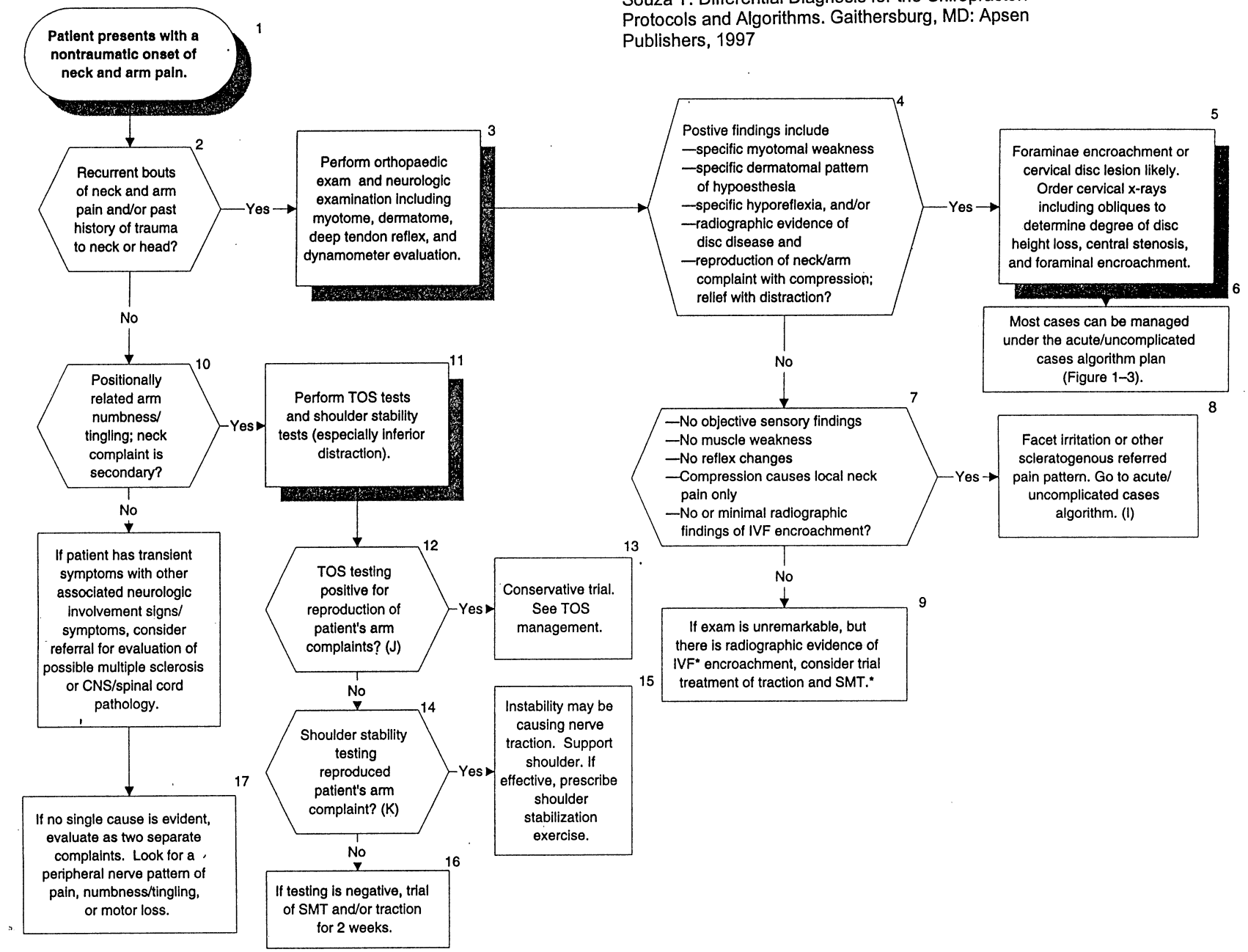


Key: SMT, Spinal manipulative therapy.

Nontraumatic Neck and Arm Pain

Example Chiropractic Care Algorithm

Souza T. Differential Diagnosis for the Chiropractor: Protocols and Algorithms. Gaithersburg, MD: Apsen Publishers, 1997

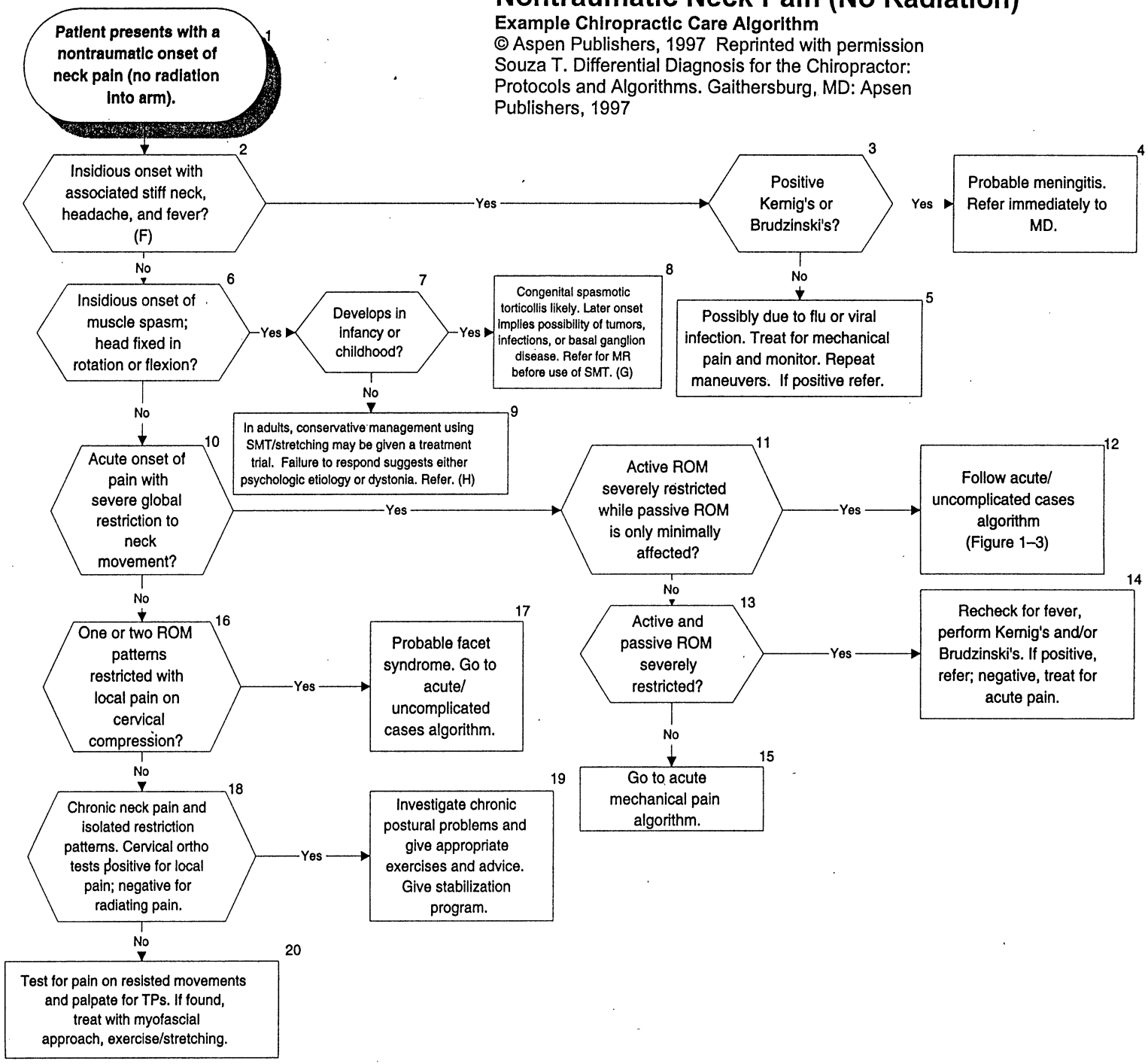


Key: IVF, intervertebral foramina; SMT, spinal manipulative therapy.

Nontraumatic Neck Pain (No Radiation)

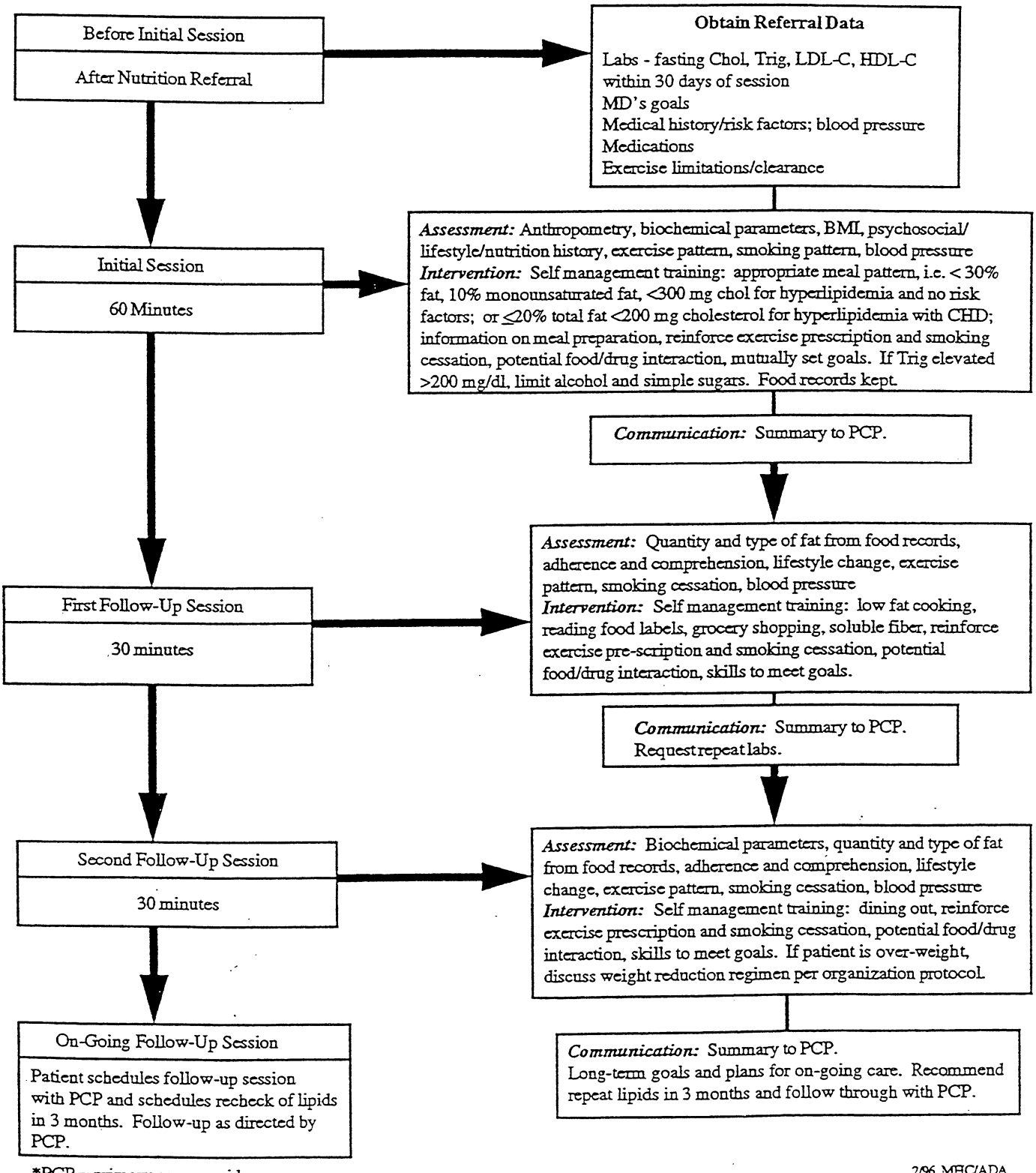
Example Chiropractic Care Algorithm

Souza T. Differential Diagnosis for the Chiropractor: Protocols and Algorithms. Gaithersburg, MD: Apsen Publishers, 1997



Key: TP, trigger point.

Hyperlipidemia
Medical Nutrition Therapy Protocol



*PCP = primary care provider

HYPERLIPIDEMIA

Medical Nutrition Therapy Protocol

Setting: Ambulatory Care (Adult 18+ years old)
Number of sessions: 3

No. of interventions	Length of contact	Time frame between interventions	Cost/charge
1	60 minutes	3-4 weeks	
2	30 minutes	3-4 weeks	
3	30 minutes	as prescribed by PCP - recheck lab in 3 months	

Expected Outcomes of Medical Nutrition Therapy

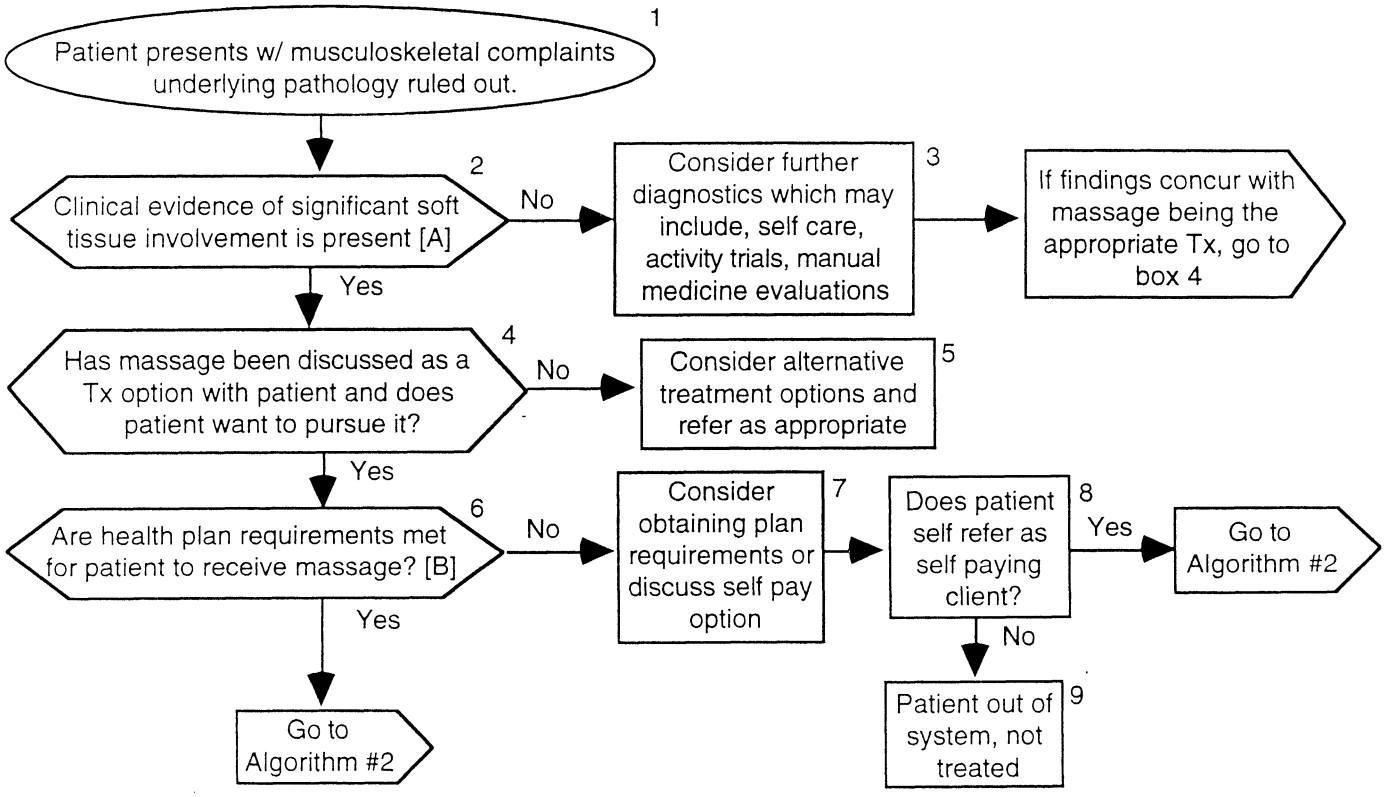
OUTCOME ASSESSMENT FACTORS	Base-line	Evaluation of Intervention		EXPECTED OUTCOME	IDEAL/GOAL VALUE
	Intervention				
	1	2	3		
Clinical Outcomes					
• Biochemical Parameters (measure < 30 days prior to nutrition session) -Lipid profile (blood Chol, Trig, LDL-C, HDL-C)	✔		✔	Chol ↓ 20% Trig-↓ or no change LDL-C ↓ HDL-C ↑ or no change Ratio TC/HDL ↓ or no change	Chol—<200-mg/dL Fasting Trig– <250 mg/dL LDL-C—<130 mg/dL (non CHD) LDL-C—<100 mg/dL (w/CHD) HDL-C >35 mg/dL Ratio TC/HDL—<4.5
• Anthropometrics -Weight , initial BMI	✔	✔	✔	↓, ↑ or maintain as appropriate	Within reasonable body weight
• Clinical Signs and Symptoms	✔		✔	As appropriate: ↓ in retina deposit ↓ shortness of breath ↓ in angina	
Behavioral Outcomes*					MNT Goal:
• Dietary fat and cholesterol intake		✔	✔	• Limits foods ↑ in chol, total fat & saturated fat • Uses monounsaturated fat as preferred fat	Fat and cholesterol consumed follows nutrition prescription i.e., <20% total fat, 10% MUSF, etc.
• Food label reading			✔	• Accurately reads food label	
• Knowledge of soluble fiber			✔	• Increases intake of foods ↑ in soluble fiber	
• Recipe modification			✔	• Modifies recipes to ↓ total fat/saturated fat	
• Food preparation			✔	• Uses low fat cooking techniques	
• Dining out		✔	✔	• Selects appropriately from restaurant menu	
• Simple sugar and alcohol intake	✔	✔	✔	• Limits per nutrition perscription, if applicable	
• Exercise pattern	✔	✔	✔	• Participates in aerobic activity 3x/wk, 45 min sessions	
• Smoking	✔	✔	✔	• Verbalizes importance of smoking cessation	
• Potential food/drug interactions	✔	✔	✔	• Verbalizes potential food/drug interaction	

*Session in which behavorial topics are covered may vary according to patient's readiness, skills, resources and need for lifestyle changes.

DRAFT SEED ALGORITHM FOR EDUCATING REFERRING CLINICIANS, HEALTH PLANS AND NETWORKS ABOUT CLINICAL MASSAGE APPROACHES
OCTOBER 1999

Disclaimer: *This document is a clinical management draft of a proposed algorithm and is not for diagnostic or treatment purposes. It has not been reviewed or approved by any school, association or other organization of the massage profession.*

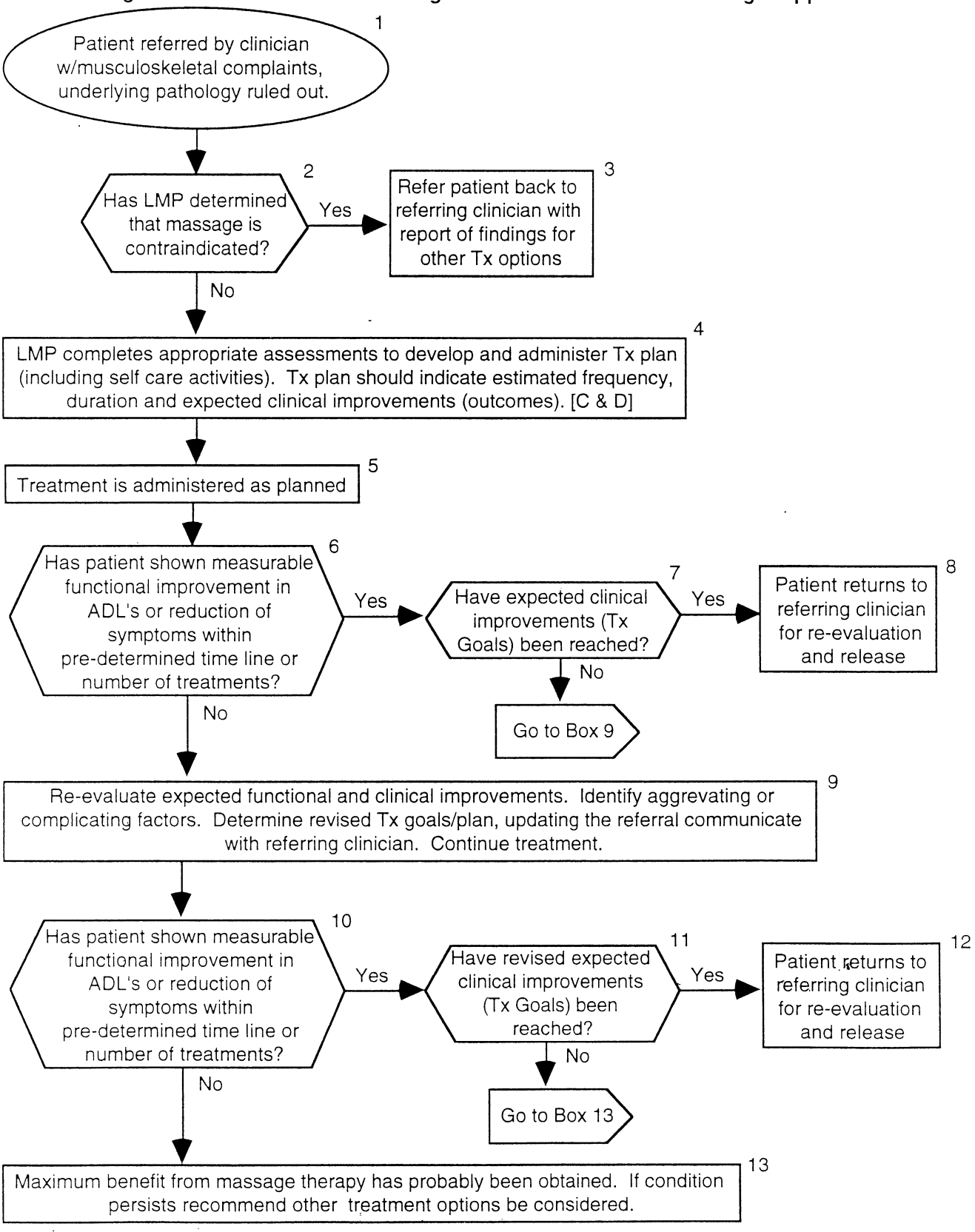
Algorithm #1 - Expectations Massage practitioners have of Referring Clinicians



DRAFT SEED ALGORITHM FOR EDUCATING REFERRING CLINICIANS, HEALTH PLANS AND NETWORKS ABOUT CLINICAL MASSAGE APPROACHES
OCTOBER 1999

Disclaimer: *This document is a clinical management draft of a proposed algorithm and is not for diagnostic or treatment purposes. It has not been reviewed or approved by any school, association or other organization of the massage profession.*

Algorithm #2 - Licensed Massage Practitioner Clinical Massage Approach



Massage Algorithm Annotations

Please note that Boxes 1-9 represent steps referring clinician should take to assess appropriateness of referral for massage treatment.

A. Clinical evidence - key indicators of soft tissue injury, may include but are not limited to:
   1. History of mechanical (traumatic or gradual) onset - determined through health Intake, interview and assessment.
   2. Symptoms are reproduced through mechanical tests.

B. Requirements - what does plan allow and require?
   1. Massage therapy benefits?
   2. Reimbursement to LMP's?
   3. Written referral?
   4. Pre-authorization of treatment by referral services?
   5. Massage benefits for specific diagnoses only?

C. Assessment methods may include but are not limited to:
   1. Written health intake and interview
      a. Identification of pain - location, intensity, frequency and duration (may include but is not limited to use of pain scale)
      b. ADL limitations
      c. Environmental and ergonomic influences
   2. Observations regarding
      a. Postural analysis
      b. Movement analyses
   3. Palpation
   4. Clinical evaluations including
      a. Range of Motion (Active, Passive and Resistive)
      b. Special tests for possible neurological involvement

D. Treatment and self care plans are based on the patients age, general health, severity of the condition, stage of healing cycle, typical activity level, abilities, level of motivation for follow through, and other simultaneous treatments being administered by other providers.

E. Clinical Improvements are observable in the clinical environment (may include but is not limited to use of manual tests, interview)

Abbreviations Key

ADL = Activities of Daily Living
LMP = Licensed Massage Practitioner
Tx = Treatment

Midwives' Association of Washington State
c/o Seattle Midwifery School • 2524 16th Ave South, Room 300 Seattle, WA 98144
(206) 860-4120

PRACTICE GUIDELINES FOR RISK SCREENING AND INDICATIONS FOR CONSULTATION AND REFERRAL FOR OUT-OF-HOSPITAL BIRTH

Licensed Midwives and Certified Nurse Midwives are specialists in the normal childbearing cycle. When problems arise which deviate significantly from the normal prenatal, intrapartal or postpartum course, midwives consult with a physician regarding the client's care or, in some cases, refer the client to a physician.

Evaluation of the childbearing woman is an on-going process which begins during the initial prenatal consultation and continues through the completion of care in the postpartum period. Risk screening is the assessment of conditions which may indicate a deviation from normalcy and the identification of those conditions which require physician involvement. In making this assessment, a midwife relies on her training, skill, and clinical judgment. There are only a few conditions which are absolute contraindications to out-of-hospital birth. There are other conditions which individually or cumulatively may indicate a trend toward abnormality.

This document is representative and not an exhaustive list of the conditions that a midwife may encounter. This document is not meant to replace the clinical judgment or experience of the midwife. There may be variations based on agreements between individual midwives and their consulting physician. New clinical practices may be undertaken in adherence to the Midwives' Association of Washington State's *Mechanism for Introducing New/Unconventional Clinical Practice*, or the American College of Nurse Midwives' *Guidelines for the Incorporation of New Procedures into Nurse Midwifery Practice.*

I. Pre-existing Conditions

The following maternal conditions existing prior to the current pregnancy require that a physician be consulted and may require physician referral:

1. Cardiovascular Disease/Hypertension
2. Pulmonary Disease/Active tuberculosis/asthma if severe or uncontrolled by medication
3. Renal Disease
4. Hepatic Disorders
5. Endocrine Disorders
6. Significant Hematological Disorders
7. Collagen-Vascular Diseases
8. Neurologic Disorders
9. Cancer
10. Infectious Diseases; the treatment of which is beyond the midwife's scope of practice
11. Current alcoholism or abuse
12. Current drug addiction or abuse
13. Current severe psychiatric illness
14. Isoimmunization
15. Previous C-section with classical incision
16. Inadequate home environment/support structures for mother and infant
17. Other significant deviations from normal as assessed by the midwifery staff

II. Antepartum Conditions

The following conditions arising during current pregnancy require that a physician be consulted and may require physician referral:

1. Labor before the completion of 37 weeks gestation
2. Presentation other than vertex at term
3. Multiple gestation
4. Significant bleeding
5. Gestational Diabetes Mellitus uncontrolled by diet
6. Severe anemia
7. Evidence of PIH or pre-eclampsia
8. Documented IUGR
9. Thrombophlebitis
10. Known fetal anomalies or conditions affected by site of birth, with an infant compatible with life
11. Fetal demise after 12 completed weeks gestation
12. Abnormal fetal NST
13. Abnormal ultrasound findings
14. Isoimmunization
15. Documented placental abnormalities, or previa
16. Post-dates pregnancy (>42 completed weeks)
17. Positive HIV antibody test
18. Parent(s) ill prepared for out-of-hospital birth
19. Inability of client and midwife to come to an agreement regarding plan of care
20. Development of any of the conditions listed previously
21. Other significant deviations from normal as assessed by the midwifery staff

III. Intrapartum Conditions

The decision to transport at any time during labor or the postpartum period will be based on any serious deviations from the normal course of events. The following conditions arising during labor require that a physician be consulted and may require physician and/or hospital referral. It should be noted that in some intrapartum situations, because of time urgency, it may not be prudent to pause management long enough to seek physician consultation before management is given.

1. Abnormal fetal presentation
2. Maternal fever
3. Hypertension with or without additional signs or symptoms of pre-eclampsia
4. Thick meconium stained fluid with delivery not imminent
5. Persistent and/or severe fetal distress
6. Significant abnormal labor pattern in active labor
7. Abnormal bleeding
8. Maternal seizure
9. ROM > 24 hours with unknown or GBS+ status
10. Prolapsed cord
11. Anaphylaxis
12. Active genital herpes in labor
13. Adhered placenta or retained without bleeding
14. Client's desire for pain medication, consultation or referral
15. Development of any of the conditions listed previously
16. Other significant deviations from normal as assessed by the midwifery staff

IV. Postpartum Conditions

The following maternal conditions arising during postpartum require that a physician be consulted and may require physician referral.

1. Seizure
2. Significant hemorrhage not responsive to treatment
3. Sustained maternal vital sign instability
4. Uterine prolapse
5. Lacerations, repair of which is beyond midwife's level of expertise
6. Development of any of the conditions listed previously
7. Other significant deviations from normal as assessed by midwifery staff

V. Neonatal Conditions

The following conditions arising in a neonate require that a pediatric physician be consulted and may require referral.

1. Persistent respiratory distress
2. Persistent cardiac irregularities
3. Central cyanosis or pallor
4. Prolonged temperature instability
5. Prolonged glycemic instability
6. Seizure
7. Apgar score less than 7 at five minutes of age
8. Birth weight <2000 grams
9. Significant clinical evidence of prematurity
10. Significant jaundice or jaundice prior to 24 hours
11. Loss of >10% of birth weight/failure to thrive
12. Major apparent congenital anomalies
13. Birth injury requiring medical attention
14. Other significant deviations from normal as assessed by midwifery staff

Dollars and Sense:
MIDWIFERY CARE IS COST-EFFECTIVE CARE

MIDWIFERY FACT SHEET

Soaring health care costs effect every American. Third party payors, small businesses, labor unions and families without health insurance are all struggling with the spiraling cost of health care in our country. Today, as the move toward "Health Care Reform" gains momentum, we face a dilemma: how to reduce health care costs while improving the access to and quality of health care services. In the area of maternity care, research has shown that midwives offer quality care at significantly less cost.

Midwifery fees are lower.

In 1992, midwifery fees averaged $1900 for comprehensive maternity care, while physician charges averaged $2500.[1]

Midwives use fewer expensive technologies to provide safe care.

Studies have consistently shown that midwives use less medications, electronic fetal monitoring and episiotomy than do physicians. Additionally, midwifery clients experience fewer cesarean sections.[2-4] Consequently, all charges, including length of hospital stay, are significantly reduced.

Midwifery care is preventive care.

Midwives spend more time to provide education, information and social support to their clients. All of these factors have been cited as significant contributors to reducing adverse outcomes, especially prematurity and low birthweight, for which our entire society pays a high price.[5,6]

Midwives providing birth care outside of hospitals are cost effective.

Out-of-hospital births for healthy women, either at home or in a licensed birth center, offer dramatic savings in health dollars. Consider that in 1991 there were 78,346 births in Washington State; approximately 75% were considered "low risk". If a modest 15% of these low risk births had been attended by a midwife out-of-hospital, Washington citizens would have saved 28.8 million dollars! These potential savings are shown in the following table.

	Midwife-attended: Out-of-hospital		*Low-risk: In-hospital*	
	Cost [a]	% births [b]	Cost [a]	% births [b]
Normal vaginal delivery	$2000	84.2	$6000	79.6
Complicated vaginal delivery	$9500 [c]	11.4	$7500	10.0
Cesarean delivery	$12,000 [c]	4.4	$10,000	10.4
Total average cost	$3295		$6566	
Savings per out-of-hospital birth	***$3271***			

a—Cost estimates from surveys of Washington midwives and hospitals.[1]

b—Rates of hospital transfer and cesarean section from the National Birth Center Study.[7]

c—Births requiring transfer to hospital during labor include midwife fee plus physician/hospital charges.

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Midwifery care reduces malpractice claims.

In a 1988 survey only 9.6% of nurse-midwives said they had been named in a suit.[8] A 1990 survey revealed that fully 77% of obstetricians had been sued at least once.[9] Therefore, malpractice insurance premiums for midwives have averaged one-sixth the cost of policies for physicians.

Increased use of midwives would reduce the costs of training maternity care providers.

In many other countries, where midwives are the primary maternity care providers, it would be considered an expensive misuse of limited health care resources for physicians to routinely care for healthy pregnant women. In our country, a shift to training more midwives and fewer obstetricians would save an enormous amount of money. The Office of Technology Assessment compared the cost of training a physician in 1985 with the cost of training a certified nurse-midwife with a Master's degree: $86,100 vs. $16,800. [10]

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Guideline for Non-Pharmacological Pain Management in Labor

Foster the development of trust
Evaluate coping mechanisms
Educate, inform, support throughout labor
Continuous presence of midwife in active labor
Use of non-pharmacological pain relief measures as clinically indicated
- Maternal movement
- Counter-pressure
- Superficial heat and cold
- Hydrotherapy
- Touch and massage
- Acupressure
- Transcutaneous electrical nerve stimulation (TENS)
- Intradermal injection of sterile water
- Aromatherapy
- Attention focusing and distraction
- Hypnosis
- Music and audioanalgesia
- Nourishment and fluids
- Homeopathy and herbal tinctures

Reassurance of normalcy
Frequent encouraging and comforting statements
Coach primary support person in methods as appropriate to skill and interest
Transport for pharmacological pain relief, maternal exhaustion and/or at mother's request

NOVEMBER 17, 1998
DRAFT #1

Guideline for Non-pharmacological Pain Management in Labor

	Current Practice	Pain Management Guideline
Benefits	▪ Status Quo	▪ Increased client satisfaction[i] ▪ Locus of control with mother[ii] ▪ Reduced length of labor[iii] ▪ Reduced likelihood of cesarean delivery[iv] ▪ Decreased perineal trauma[v] ▪ Longer duration of breastfeeding[vi] ▪ Decreased difficulty in mothering[vii]
Harms	▪ Anesthesia and analgesia associated increase in operative deliveries[viii] ▪ Maternal morbidity associated with operative deliveries[ix] ▪ Infant morbidity associated with pharmacological pain relief [x] ▪ Delayed breastfeeding ▪ Locus of control with hospital personnel	▪ None apparent[xi] ▪ Possible delayed pharmacological pain relief due to transport time
Costs	▪ $6566 total average cost of low-risk birth in hospital[xii]	▪ No additional costs above basic midwifery charge ▪ Total average cost of midwife attended out-of-hospital $3295[xiii] ▪ $3271/average savings per out of hospital birth [xiv]

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[i] "Support During Childbirth," *Cochrane Collaboration Pregnancy and Childbirth Database*, 1995, Issue 1, pp. 5.
[ii] ibid.
[iii] ibid., pp. 4.
[iv] ibid., pp. 5.
[v] ibid.
[vi] ibid.
[vii] ibid.
[viii] Enkin, M. et al, "Control of Pain in Labor," *A Guide to Effective Care in Pregnancy and Childbirth*, Oxford University Press, New York, 1995, Chapter 34.
[ix] ibid.
[x] ibid., pp. 9, 10, 12.
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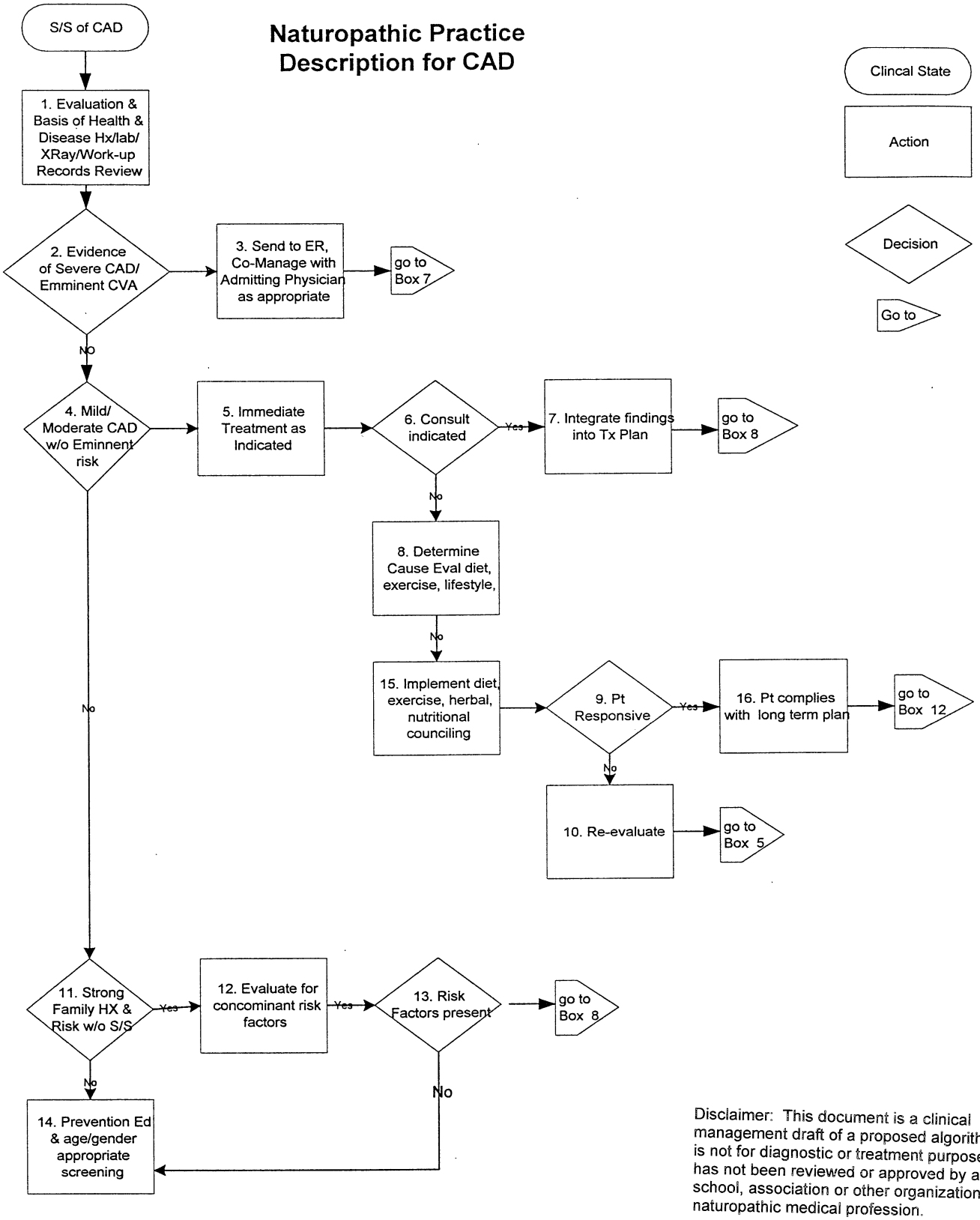
[xii] Midwives' Association of Washington State, "Dollars and Sense: Midwifery Care is Cost-Effective," *Midwifery Fact Sheet*, June 1993.
[xiii] ibid.
[xiv] ibid.

Naturopathic Practice Description for CAD



Disclaimer: This document is a clinical management draft of a proposed algorithm and is not for diagnostic or treatment purposes. It has not been reviewed or approved by any school, association or other organization of the naturopathic medical profession.

CWIC CAD Guideline

CWIC CAD Guideline for Naturopathic Physician's

A- Patient may have any or all of the following symptoms;

-angina, leg cramps, gradual mental deterioration, impotence, weakness, dizziness, hx. of CVA, MI or stroke, elevated serum lipids, + fam. hx., established CVD, CAD, thrombophlebitis, and so on..

- presence of poor diet, lifestyle conducive to CAD, smoking, drug abuse, sedentary

B. Implementation of SF 36, or other appropriate Rating Scale or Questionnaire for measuring physical disability and handicap, social health, psychological well-being, depression, mental status, and general health status and quality of life, may be useful in measuring health outcomes of naturopathic interventions, and making clinical decisions.

Recommended lab-work includes CBC/Diff/ESR/ PT or PTT, CRP. Lipoprotein A, Homocysteine, cardiac enzymes and so on (need Harrison's for this).

C. We may be able to create monographs to refer to for HTN, Diabetes, Familial Hypercholesterolemia, Diabetes, Obesity etc. that are often concomitant conditions with CAD. These would then be annotated Into our boxology. We can also create monographs for-diet therapy

- -herbal medicines
- -nutritional medicines
- -exercise therapy
- -physical medicines
- -homeopathy
- -stress management
- -pharmacology

Naturopathic Primary Care Management of Otitis Media

September 1999 by Baldwin, May and Stretch

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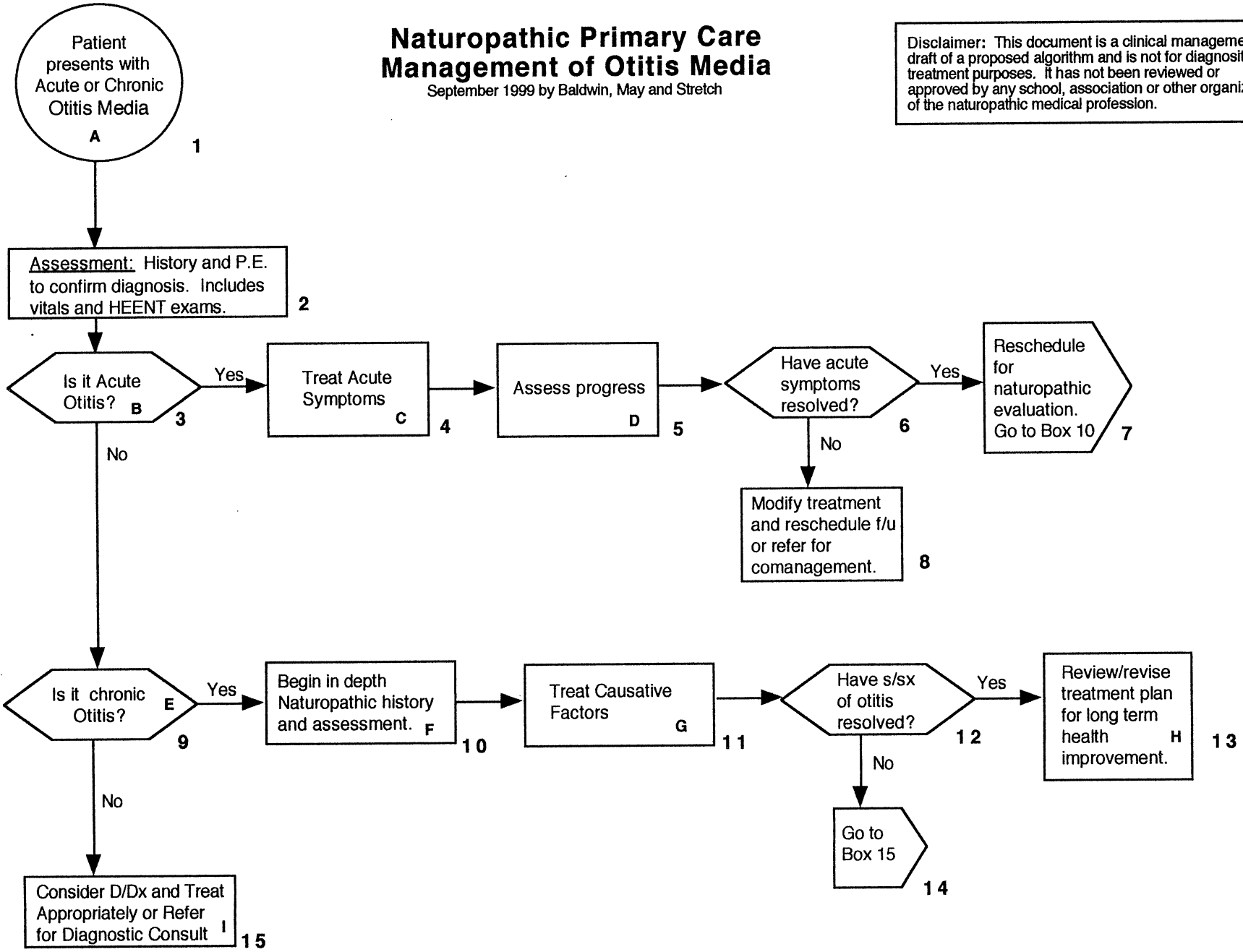

Naturopathic Primary Care Management of Otitis Media

September, 1999 by Baldwin, May and Stretch

Definition of Problem:

Childhood otitis media (OM) is second only to the common cold as a cause of illness in pre-school aged children. It accounts for 1/3 of all office visits (approximately 30 million visits per year) second only to well child/baby visits. Despite aggressive use of antibiotics and surgical intervention, office visits for OM have increased dramatically from the 1970's to the 1990's. It is most common in developed countries. In North America, more than 80% of children will have had at least one episode, and 46% of these will have at least three episodes by age 3. By age 7, 93% of children have one or more episodes of OM. Approximately 20% have six or more episodes by age 6 and are considered "otitis prone". Ten percent will have chronic and persistent OM and hearing loss. Annual costs associated with OM are estimated to be 3.5 billion dollars.

There are three main types of otitis media:

Acute Otitis Media (AOM)- a bacterial or viral infection in the middle ear, usually secondary to a URI and is most common in children ages 3 months to three years.

Serous Otitis Media- an effusion (clear fluid) in the middle ear resulting from incomplete resolution of AOM or obstruction of the eustachian tube and is common in children.

Chronic Otitis Media- a permanent perforation of the tympanic membrane resulting from AOM, blocked eustachian tube, mechanical trauma, thermal or chemical burns or blast injuries.

Etiology:

There are many factors contributing to the cause of OM. Among them are the anatomy of the eustachian tube in the infant being level, allowing for easy migration of organisms into the middle ear, mechanical obstruction which may include TMJ dysfunction, occipital and cervical spine misalignment, overbite and narrow dental arches, nutritional deficiencies, food and environmental allergies, and bacterial and viral infections. The most common risk factors include second hand smoke from a mother who smokes, day care attendance, male gender, a sibling with a history of recurrent OM, early occurrence of OM, no breast feeding, early bottle feeding, and family history of allergies.

Diagnosis:

Diagnosis is usually made on clinical grounds. Although serous OM can be asymptomatic there still may be a bulging tympanic membrane with impaired mobility (as observed by pneumatic otoscopy) on physical exam. OM is often associated with earache, sometimes a fever, accompanying URI symptoms, and decreased hearing. Physical exam may also reveal an opaque, often yellowish or inflamed eardrum. A hearing test may be necessary to establish the level of hearing loss. WBC higher in AOM than serous or chronic OM.
Tympanocentesis may be necessary for microbiological diagnosis in treatment failures.
Make sure to do a full ENT exam to help rule out obstruction or serious complications.

Differential Diagnosis and Complications:

Differential includes mumps, toothache, otitis externa, foreign body, ear canal furuncle, impacted cerumen, TMJ dysfunction, tympanosclerosis.
Symptoms of an impending complication include headache, sudden profound hearing loss, vertigo, chills and fever and may indicate acute mastoiditis, meningitis, labyrinthitis, facial paralysis, conductive and sensorineural hearing loss, epidural abscess.

Draft

Naturopathic Primary Care
Management of Otitis Media

Annotations

A. Childhood otitis media (OM) is second only to the common cold as a cause of illness in pre-school aged children. It accounts for 1/3 of all office visits (approximately 30 million visits per year) second only to well child/baby visits. In North America, more than 80% of children will have had at least one episode, and 46% of these will have at least three episodes by age 3. By age 7, 93% of children have one or more episodes of OM. Acute OM is usually self-limiting lasting up to three weeks. Annual costs associated with OM are estimated to be 3.5 billion dollars.

B. Acute Otitis Media (AOM)- a bacterial or viral infection in the middle ear, usually secondary to a URI and is most common in children ages 3 months to three years. Serous Otitis Media- an effusion (clear fluid) in the middle ear resulting from incomplete resolution of AOM or obstruction of the eustachian tube and is common in children.

C. See attachment.

D. If symptoms resolved within 48 hours (possibly assessed by phone call), schedule a follow up visit for 3 weeks. If still symptomatic then schedule a visit immediately to reassess.

E. Chronic Otitis Media- a permanent perforation of the tympanic membrane resulting from a blocked eustachian tube, mechanical trauma, thermal or chemical burns or blast injuries.

F. In depth naturopathic assessment is in development and includes causative factors such as environment, lifestyle, diet and constitution contributing to concomitant health conditions and risk factors. See Etiology on front page for some specifics.

G. See attachment.

H. Review and or revise treatment plan. Average number of office visits is 2 to 3 over a 4 to 6 month period.

I. Differential diagnosis includes mumps, toothache, otitis externa, foreign body, ear canal furuncle, impacted cerumen, TMJ dysfunction, tympanosclerosis. Symptoms of an impending complication include headache, sudden profound hearing loss, vertigo, chills and fever and may indicate acute mastoiditis, meningitis, labyrinthitis, facial paralysis, conductive and sensorineural hearing loss, epidural abscess.

Therapeutic Attachment: Otitis Media

Key **a. Diet** **b. Lifestyle** **c. Botanicals** **d. Homeopathy** **e. Physical medicine** **f. Therapeutic nutrition**

1. Pain Control (Analgesia)

a. Breast-feed if not weaned
a. Rest/sleep
b. Mullein-garlic ear drops. May add aconite, hypericum or belladonna, verbascum, if severe. Do not use ear drops if tympanic membrane is not intact.
c. Chamomile, Kali mur, Kali sulph, Pulsatilla, Calcarea, Belladonna, etc. per patients symptoms.
d. Onion or carrot poultice, wet sock treatment, heat pack, contrast hydrotherapy

2. Acute Immune Support

a. Decrease simple sugars, light whole foods diet
b. Avoid tobacco smoke, adequate rest
c. Echinacea, Larix
e. Vitamin C: age x 100 mg every two hours
Vitamin A: age x 10,000 IU/day with 50,000 IU maximum for up to two days in children under age 6 and up to four days in children over age 6.

3. Decongestion/lymphatic & Mucus Membrane Support

a. Decrease dairy, sugar, fruit juices
b.
c. Sambucus, gallium, euphrasia, calendula, plantago
d.
e. Steam inhalation. May add essential oils eucalyptus. Eustachian tube stimulation.
f. NAC, zinc, beta-carotene

4. Antimicrobial

a. Garlic, hydrastis, berberis
b.
c. Berberis, thymus, coptis, Echinacea
d.
e. Steam inhalation. May add essential oils including thyme
f. Vitamin C, zinc, selenium

5. Long-term immune support and prevention

a. Whole foods diet with adequate protein and nutrients, especially vitamins C & A, beta- carotene or mixed carotonoids, zinc. If necessary, eliminate other allergens such as eggs, corn, oranges, peanuts and soy for at least 2 months and then rotate into diet. Don't allow child bottle feeding to drink while in the supine position

b. Regular exercise/rest schedules
c. Astragulus, mushrooms including shitake

d. Thymus extract
e. Cranial sacral soft tissue manipulation
f. Supplementation for 3 to 16 weeks with any of the following nutrients depending on patient profile: Probiotics, essential fatty acid, vitamins C, A, beta-carotene, and zinc

Vitamin C guidelines:

50 mg/day for 6-18 months
100 mg/day for 18 months-3 years old
150 mg/day for 3-4 1/2 years old
200 mg/day for 4 1/2-6 years old
250 mg/day for 6 – 8 years old

Vitamin A guidelines:

1000-2000 IU/day for 6-18 months
2000-2500 IU/day for 18 mo.-3 years of age
2500-3000 IU/day for 3-4 1/2 years of age
3000-4000 IU/day for 4 1/2 – 6 years old
4000-5000 IU/day for 6-8 years old

Beta-carotene

3000-9000 IU/day for 6-18 months
9000-15,000 IU/day for 18 mo.-3 years of age
15,000-20,000 IU/day for 3-4 1/2 years of age
20,000-25,000 IU/day for 4 1/2 – 6 years old
25,000-28,000 IU/day for 6-8 years old

Zinc

2-4 mg/day for 6-18 months
4-6 mg/day for 18 months-3 years old
6-8 mg/day for 3-4 1/2 years old
-10 mg/day for 4 1/2-8 years old

APPENDIX J: Resource List

RESOURCE LIST

This list of resources is not to be considered complete, and exhaustive. The references listed here is a partial list intended to direct readers to some references that will provide detailed information available about some of the CAM professions that participated in CWIC. This list includes some text references, scientific information, professional associations and other related publications that may assist the readers in their learning process about some of the professions considered to be CAM.

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Professional Associations

Acupuncture
Acupuncture Association of Washington
PO Box 31385
Seattle, WA 98103
206-329-9094
President: Christopher Huson

National Acupuncture and Oriental Medical Alliance
14637 Starr Rd. SE
Olalla, WA 98359
253-851-6896
www.acuall.org
Executive Director: Barbara Mitchell

Chiropractic
Washington State Chiropractic Association
13540 Linden Avenue North
Seattle, WA 98133
206-364-6628
www.chirohealth.org
Executive Director: Bruce Frickelton

International Chiropractic Association
1110 N. Glebe Rd., #1000
Arlington VA 22201
800-423-4690

American Chiropractic Association
1701 Clarendon Blvd.
Arlington, VA 22209
800-986-4636

Dietetics
Washington State Dietetic Association
23607 Highway 99, Suite 2-C
Edmonds, WA 98026
425-778-6162
www.nutritionwsda.org
Executive Director: Robin Barry

American Dietetic Association
216 West Jackson Blvd.
Chicago, IL 60606-6995
312-899-0040
www.eatright.org

Massage Therapy
American Massage Therapy Association, Washington Chapter
PO Box 2242
Bothell, WA 98041-2242
888-302-3555
Amtawa@aol.com
Administrative Director: Cathy Olson

American Massage Therapy Association
820 Davis Street, Suite 100
Evanston, IL 60201
847-864-0123
www.amtamassage.org
Executive Director: Marlys Sperger

Licensed Midwifery
Midwives Association of Washington State
PO Box 1699
Port Townsend, WA 98368
President: Suellen Jeffrey

Midwives Alliance of North America
4805 Lawrenceville Highway, Suite 116-279
Lilburn, GA 30047
888-923-6262
Info@mana.org

Naturopathic Physicians
Washington Assn. of Naturopathic Physicians
4224 University Way NE, Suite J
Seattle, WA 98105
206-547-2130
www.wanp.org
Association Manager: Lisa Gates

American Association of Naturopathic Physicians
601 Valley Street, Suite 105
Seattle, WA 98109
206-298-0126
www.aanp.org
Executive Director:

General
National Center for Complementary and Alternative Medicine (NCCAM)
National Institutes for Health
Building 31, 5B-37
Bethesda, MD 20892

Examples of CAM Clinical and Scientific Journals

- ***Accupunture and Electro-Therapeutics Research*** Publisher: International College of Acupuncture and Electro-Therapeutics, Elmsford, NY
- ***Advances: The Journal of Mind-Body Health*** Publisher: John E. Fetzer Institute, Kalamazoo, MI
- ***Alternative Therapies in Clinical Practice Publisher:*** Prime National Corporation, Weston, MA
- ***Alternative Therapies in Health and Medicine*** Publisher: InnoVision Communications, Aliso Viejo, CA, Div. of American Assn. of Critical-Care Nurses
- ***American Journal of Chinese Medicine*** Publisher: Institute for Advanced Research in Asian Science and Medicine Garden City, NY
- ***Chiropractic Research Journal*** Publisher: Life University School of Chiropractic, Marrietta, GA.
- ***Integrative Medicine*** Publisher: Science Direct, New York, NY.
- ***Journal of Alternative and Complementary Medicine.*** Publisher: Mary Ann Liebert, Inc., Larchmont, NY.
- ***Journal of Manipulative and Physiological Therapeutics.*** Publisher: Mosby, St. Louis, MO.
- ***Journal of Natural Therapeutics***. Norwalk, CT. ISSN: 1047-7837 SR 0070432
- ***Mind/Body Medicine: A Journal of Clinical Behavioral Medicine*** Publisher: Decker Periodicals, Hamilton, Ontario, Canada.
- ***Stress Medicine*** Publisher: John Wiley & Sons, Ltd., New York, NY
- ***Topics in Clinical Chiropractic.*** Publisher: Aspen Publishers, Gaithersburg, MD.